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2009 report on the state of the drugs problem in Europe

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Social consequences of harmful use of alcohol

The Health Research Board launched the latest publication in its Overview series on 25 November 2009.[1] The purpose of Overview 9 was to compile and analyse the available data on the social consequences of harmful use of alcohol in Ireland and the methods used involved a combination of archival data, survey results and research literature.

The negative social consequences of alcohol include spouse/family problems, public disturbances, violence, and reduced work performance, which impact on all facets of society. Harmful use of alcohol has a negative effect on family well-being, and can contribute to relationship and marriage problems and impact on children, who are especially vulnerable to the effects of parental drinking. The effects of alcohol can undermine the fabric of family life and in many cases leave a legacy of neglect, abuse, chaos and damaged children. The emotional cost borne by these families is huge.

Garda data were analysed for the years 2003–2007 to examine the contribution of alcohol to crime in Ireland. Between 2003 and 2007 the total number of drunkenness, public order and assault offences increased by 30%, from 50,948 to 66,406. The typical profile of a drunkenness, public order or assault offender was that of a young male aged under 24 years. Young people aged 18–24 were responsible for two-fifths of offences. Those aged under 18 years accounted for 17% of offenders, and the total number of offences among minors increased from 6,531 in 2003 to 10,037 in 2007, an increase of 54%.

Approximately half of all offences occurred at the weekend. Just under half of adult offences occurred between midnight and 4.00 am, with a peak at 2.00 am, which coincides with weekend closing time in many licensed premises, when large volumes of people spill onto the streets, often in a state of intoxication. Drunkenness and public order offences among minors tended to occur earlier at night than those among the adult population. The number of offences was highest for the week during which St Patrick's Day occurs, the last week in October and the two weeks around Christmas and New Year's Day.

The number of drink-driving offences increased by 74% between 2003 and 2007, from 11,421 to 19,864. The largest increase (32%) was observed between 2005 and 2006, which can be explained by the introduction of legislation permitting random breath testing in 2006.

L to r: Authors Mairea Nelson and Dr Deirdre Mongan (Health Research Board) and Dr Ann Hope

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Social consequences of harmful use of alcohol *(continued)*

Males accounted for 90% of drink driving offenders. The largest proportions of both male and female offenders were in the 18–24-year age group, followed by the 25–29-year age group. Over half (52%) of all drink-driving offences were recorded between midnight and 4.00 am, and 54% were recorded on a Saturday or Sunday.

Data from four national drinking surveys (2002–2006) were analysed to examine social harm in the general population. The likelihood of experiencing at least one of the four social harm indicators (fights, or harm to friendships, home life or work) in the previous year due to the drinker's own alcohol use was one in five (21%), with men twice as likely to report social harms compared to women (men 28%, women 13%). The overall prevalence of experiencing at least one of the social harms was significantly higher among those who engaged in weekly risky single-occasion drinking (RSOD) (36%) in comparison with less frequent risky drinkers (16%) and with those who did not engage in risky drinking (5%). Younger participants were more likely to report that they experienced fights and work problems, while harm to home life was more common among those aged 35 years and over.

Harm to others besides the drinker in the previous year was examined, using five indicators: family problems, having been a passenger with drunk driver, been hit or assaulted, had financial trouble or had property vandalised as a result of someone else's drinking. The overall prevalence of experiencing at least one of these negative consequences from someone else's drinking was over one in four (28%).

While men experienced more social harms from their own drinking than did women, both men and women experienced similar levels of harm from someone else's drinking. More women than men reported the experience of family and money problems. Family problems were experienced equally by those who drank and those who did not drink. Men were more likely to experience the negative consequences of being a passenger with a drunk driver and of being assaulted. The risk of experiencing either of these harms increased as the frequency of risky drinking by the victim increased. The younger age groups, of both men and women, were more likely to report experiencing assaults and being a passenger with a drunk driver.

The harmful use of alcohol is a serious public health problem in Ireland, and is a major factor in social problems such as violence, family disharmony and child abuse and neglect. Alcohol-related harm is not restricted to the individual drinker, but has negative consequences for families, innocent bystanders and the wider community. The findings of this Overview illustrate the urgent need for the introduction of a co-ordinated national alcohol strategy.

(Deirdre Mongan)

1. Mongan D, Hope A and Nelson M (2009) *Social consequences of harmful use of alcohol in Ireland.* HRB Overview Series 9. Dublin: Health Research Board.

'Message in a Bottle' seminar

'Message in a Bottle', an alcohol policy seminar, was hosted by Ballymun Local Drugs Task Force and Dublin North East Local Drugs Task Force in the Carlton Airport Hotel, Santry, on 16 September. The purpose of the conference was to improve current knowledge and understanding of issues relating to alcohol at an individual, societal and environmental level. It was felt that, with a better understanding of policy and practice, local communities would be able to inform policy both locally and nationally. Keynote speakers on the day were Mr Peter Sheridan and Dr Ann Hope. Mr Sheridan is an acclaimed film and theatre director and he shared his personal experiences of alcohol. Dr Hope has extensive experience in national and international work in alcohol policy.

In her presentation she discussed alcohol policy from an Irish perspective and outlined the policy interventions that are most effective in reducing alcohol-related harm. Seven guest speakers presented a diverse range of topics relating to alcohol policy, drinking culture, alcohol treatment and alternative alcohol-free social gatherings.

(Vivion McGuire)

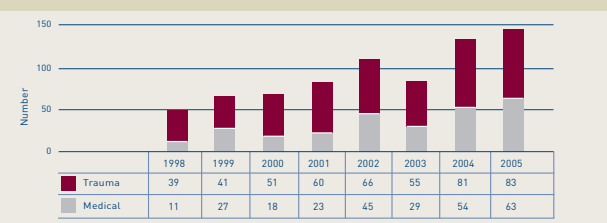
Trends in drug-related deaths in Ireland

L to r: Simone Walsh, Dr Suzi Lyons and Ena Lynn (Health Research Board) authors of the latest paper in the HRB Trends Series

The Health Research Board (HRB) published the first national report on non-poisoning deaths among drug users in Ireland in November 2009.[1] The data presented describe trends in non-poisoning deaths (deaths due to traumatic or medical causes) among drug users between 1998 and 2005. This paper is a companion to HRB Trends Series 4, which analysed trends in deaths by poisoning (directly drug-related deaths).[2] The data used for the analysis were obtained from the National Drug-Related Deaths Index (NDRDI) maintained by the Alcohol and Drug Research Unit of the HRB.

Overall, the annual number of drug-related deaths and deaths among drug users recorded in the NDRDI increased in the years 1998–2005 The total number of deaths in the eight-year period was 2,441, of which 885 (36.3%) were non-poisonings.

Of the non-poisoning deaths with a known cause (n=746), over half (476, 63.8%) were the result of trauma. Figure 1 shows that the annual number of these deaths more than doubled over the reporting period. The annual number of deaths from medical causes increased by almost 500% over the same period.



	1998	1999	2000	2001	2002	2003	2004	2005
Trauma	39	41	51	60	66	55	81	83
Medical	11	27	18	23	45	29	54	63

Figure 1 Non-poisoning deaths among drug users, NDRDI 1998 to 2005 (N=746)

Half of the deaths due to trauma were of young men aged between 20 and 29 years. The most common causes of death due to trauma were hanging (174, 36.5%) and road traffic collisions (95, 20.0%). Almost half of those involved in road traffic collisions were driving a vehicle at the time of the accident.

Alcohol was present in nearly three-fifths (241, 58.5%) of the deaths due to trauma that had a positive toxicology. Cannabis was the illicit drug most commonly found in the toxicology results of deaths due to trauma (227, 55.1%).

When the traumatic deaths that had a positive toxicology were analysed by type of death, cannabis (40, 67.8%), opiates (24, 40.7%) and cocaine (18, 30.5%) were found in the greatest proportions in deaths due to violence (shooting, stabbing or assault). MDMA (ecstasy) (26, 28.6%) was found in the greatest proportion in deaths due to road traffic collisions.

Over three-quarters of the deaths due to medical causes were of males, and the majority were aged between 30 and 44 years. The most common medical causes of death were cardiac events (67, 24.8%), followed by respiratory infections (48, 17.8%) and liver disease (31, 11.5%).

The majority (180, 66.7%) of drug users who died of medical causes had a history of opiate use. Three-fifths (19, 61.3%) of those who died of liver disease had a history of alcohol dependency. The highest numbers of cocaine users (n=12) and cannabis users (n=24) were among those who died from a cardiac event.

Of the total number of deaths (including poisoning and non-poisoning deaths) recorded by the NDRDI in the period 1998–2005, 192 (7.9%) cases had a documented history of a blood-borne viral infection. The annual number of these cases increased from nine in 1998 to 41 in 2005.

The number of drug users who have acquired a blood-borne viral infection highlights the need for continued and expanded harm reduction programmes, including treatment for problem alcohol use, to reduce the risk of infection and prevent the long-term health consequences of liver damage.

The number of drug users who died from hanging or from drowning supports the argument that substance misuse is related to suicide. There is a need for increased awareness and education around this issue, especially for those with a dual diagnosis of mental health and substance misuse problems who are already in treatment, and those who present at emergency rooms with non-fatal drug- or alcohol-related injuries.

The number of drug users who were driving at the time of their death and had a positive toxicology is further evidence of the need for more reliable statistics on drink/drug driving. There is a need for expansion of the forensic analysis programme to ascertain the true incidence of driving while under the influence of drugs and/or alcohol. Unfortunately, there is currently no reliable system of road-side testing for the presence of drugs in the body.

The correlation of toxicology and drug-use history with the type of death recorded supports the argument that drug use is contributing to the premature death of drug users in Ireland. More effective measures are required to educate drug users about the health consequences of drug use, particularly the cardio-toxic effects of cocaine.

The continuing upward trend in drug-related deaths revealed in this paper and in its predecessor, Trends Series 4, reflects the increasing numbers in the population who are consuming drugs and taking risks and who have acquired infections or developed medical conditions associated with drug use.

(Ena Lynn, Suzi Lyons, Simone Walsh and Jean Long)

This report may be downloaded from the publications section of the HRB website at www.hrb.ie.

1. Lynn E, Lyons S, Walsh S and Long J (2009) *Trends in deaths among drug users in Ireland from traumatic and medical causes, 1998 to 2005.* HRB Trends Series 8. Dublin: HRB.
2. Lyons S, Lynn E, Walsh S and Long J (2008) *Trends in drug-related deaths and deaths among drug users in Ireland, 1998 to 2005.* HRB Trends Series 4. Dublin: HRB.

What constitutes a 'standard drink'?

Alcohol has harmful properties; it is an intoxicant and a drug, and the risks associated with it are extensive. There is no clear level of drinking below which alcohol-related accidents, injuries or diseases do not occur. In other words there is no known 'safe' or 'sensible' level of alcohol consumption for any one individual. A recent report by the Health Service Executive examined the different alcoholic beverages currently available in Ireland in terms of beverage categories, the alcohol content, the serving size of typical drinks and other relevant information.[1]

There is limited evidence of an impact of alcohol warning labels on drinking behaviour and alcohol-related harm. However, a European report on alcohol and labelling[2] concluded that consumer protection principles would suggest that where there are risks to health in consuming alcohol, particularly during pregnancy, when taking medication, or when driving or operating machinery, consumers should be informed about those risks.

In Ireland, there is much confusion about what constitutes a typical or 'standard drink'. Part of the confusion stems from the use of the 'UK unit', which is inappropriate in the Irish context. The UK unit was devised in the early 1970s as a simple method to calculate the alcoholic strength in different drinks. The purpose was to help scientists and health professionals in the clinical setting estimate alcohol consumption for comparative purposes. The measure used was called a 'unit of alcohol' and related to the most common drinks and alcohol content of drinks served in the UK. A 'UK unit of alcohol' is found in a half pint of beer (3.5% ABV) or a small glass of wine (100 ml) or a single measure of spirits (1/6 gill) and equals 8 grams of pure alcohol. Although the UK unit was used in Ireland, it did not reflect the typical strength or serving measure of drinks sold in Ireland, where a single measure of spirits is larger, at 1/4 gill. It is therefore not appropriate to use the UK unit measure when describing a standard drink in Ireland.

Table 1 Alcohol content of alcohol beverages

Beverage type	Serving size description	Serving size (ml)	Alcohol content (ABV%)	Grams of pure alcohol
Beer	Half pint/glass	284	4.3	9.8
	Small can/long neck bottle	330		11.4
	Large can	500		17.2
	Pint	568		19.5
Cider	Half pint/glass	284	4.5	10.2
	Small can/long neck bottle	330		11.9
	Large can	500		18
	Pint	568		20.4
Alcopops/RTD	Long neck bottle	275	5	11
	Large bottle	700		28
Wine	Small glass	100	12.5	10
	Quarter bottle	187.5		18.8
	Half bottle	375		37.5
	Bottle	750		75
Liqueur	Glass	71	17	9.7
	Bottle	700		95.2
Sherry/port	Glass	71	20	11.4
Vodka/rum/gin	Single glass	35.5	37.5	10.7
	Double glass	71		21
	Half bottle	350		105
	Bottle	700		210
Whiskey/brandy	Single glass	35.5	40	11.4
	Double glass	71		22.4
	Half bottle	350		112
	Bottle	700		224

Source: Hope (2009)

What constitutes a 'standard drink'? *(continued)*

A pilot study undertaken in 2000 showed that a typical drink in Ireland was equal to 10 grams of alcohol and called a 'standard drink'.[3] In the international arena, a standard drink is the usual term used. The UK unit (8 grams) is the lowest standard drink measure used. Some countries, including Spain, Italy, New Zealand and Australia, use 10 grams as their standard drink measure.

To establish the standard drink in Ireland, the first step was to calculate the amount of pure alcohol in each of the alcoholic beverages. This involved multiplying the serving size of the drink (millilitres) by the alcohol content (% ABV) of the drink and dividing by 1.25 (1 ml=1.25 g) to establish the grams of pure alcohol in that specific drink (Table 1).

Two of the most popular serving sizes, a pint of beer and a quarter bottle of wine, are often mistakenly regarded as a standard drink where in fact they are equivalent to two standard drinks each. As a general guide for low-risk drinking, the recommended upper weekly limit used in Ireland is based on the UK unit – 14 units for women and 21 units for men. However, when those low risk drinking guidelines are translated into Irish standard drinks (10 grams), the Irish low risk weekly guidelines should be 11 standard drinks for women and 17 standard drinks for men. To provide a general estimate of the average number of standard drinks consumed in Ireland, the per capita figures for 2006 were utilised. This suggests that on average approximately 21 standard drinks are consumed each week by every adult aged 15 years and over. This is a conservative figure given that abstainers are not excluded and represent about 20% of the adult population. Over a year this level of drinking is equivalent to 548 pints or 143 bottles of wine or 51 bottles of vodka per adult.

It is hoped that the findings of this study will help clinicians and health professionals to more accurately assess patient alcohol intake, provide a valid measure for inclusion in alcohol screening tools and help to inform policy on product labelling and provision of other relevant health information.

(Ann Hope and Deirdre Mongan)

1. Hope A (2009) *A standard drink in Ireland: what strength?* Dublin: Health Service Executive.
2. Deutsche Hauptstelle Fur Suchtfragen e.V. (DHS) (2008) *Consumer labelling and alcoholic drinks.* Hamm: DHS (German Centre for Addiction Issues).
3. Hope A (2000) *Typical drinks in Ireland.* Dublin: Department of Health and Children.

Road Traffic Bill provides for lower BAC limits

The Road Safety Strategy 2007–2012 published in October 2007 recommended lowering the legal blood alcohol concentration (BAC) limit for drivers by June 2009. On 30 October 2009, Transport Minister Noel Dempsey TD published the Road Traffic Bill 2009, which provides for the introduction of reduced BAC limits for drivers and mandatory testing of drivers involved in collisions.[1]

The Bill provides for a reduction from the current legal limit of 80 mg of alcohol per 100 ml of blood to:

- 20 mg per 100 ml for learner, novice and professional drivers; and
- 50 mg per 100 ml for other drivers.

The aim of this Bill is to improve road safety, save lives and reduce serious injuries on our roads. According to Minister Dempsey, 'Intoxicated driving is one of the main causes of fatalities and injuries on our roads and that is not acceptable. The research in this area is conclusive and irrefutable. Reducing the BAC from its current limit of 80 mg has a proved beneficial effect and will save lives and reduce serious injuries throughout Ireland.'

However, since publication of the Bill, it has been reported that the evidential breath-testing machines used in Garda stations to measure the alcohol in a driver's breath cannot be recalibrated to the 20 mg limit proposed for inexperienced and professional drivers. The Medical Bureau of Road Safety estimates that it will be the middle of 2011 at the earliest before new replacement breath-testing machines can be purchased, tested and installed in Garda stations.[2] Alcohol is a major factor in roads deaths in Ireland and in 2003 alcohol was a contributory factor in 110 (36.5%) of 335 fatalities.[3] Lower BAC limits consistently produce positive results in relation to alcohol-related road traffic collision rates. For a driver with a BAC of 50 mg the risk of crashing a vehicle is double that for a person with a zero BAC and at the current Irish BAC limit of 80 mg the risk is 10 times greater.[4] Given the clear evidence that lower BAC limits improve road safety, it is very disappointing that we have to wait another 18 months at least for the important legislation proposed in this Bill to be enacted.

(Deirdre Mongan)

1. Department of Transport (2009) Minister Dempsey publishes Road Traffic Bill 2009. Press release dated 30 October 2009. www.transport.ie/pressRelease.aspx?Id=144
2. Labanyi D (2009, 6 November) Drink-drive changes to be delayed until 2011. *Irish Times.* www.irishtimes.com/newspaper ireland/2009/1106/1224258194074.html
3. Bedford D, McKeown N, Vellinga A and Howell F (2006) *Alcohol in fatal road crashes in Ireland in 2003.* Naas: Population Health Directorate, Health Service Executive.
4. Babor T, Caetano R, Casswell S, Edwards G, Giesbrecht N, Graham K *et al.* (2003) *Alcohol: no ordinary commodity. Research and public policy.* New York: Oxford University Press.

2009 report on the drugs situation in Europe

The annual report of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) on the drugs situation in Europe was published on 6 November.[1] While the report points to a stable situation in relation to heroin, and confirms reports of a stabilising or even declining trend in the use of amphetamines and ecstasy, cocaine use continues to rise, albeit in a small number of countries. There are between 1.3 and 1.7 million problem opioid users in the EU and Norway, with heroin responsible for Europe's largest drug-related health and social costs. Some 12 million Europeans have tried cocaine in their lifetime, compared with around 11 million for amphetamines and 9.5 million for ecstasy.

In Ireland, between 13,405 and 15,819 individuals used opiates in 2001; this estimate represents 1% of the opiate users in Europe. The picture in relation to cocaine is consistent with the broader European situation and the proportion of adults who reported having used the drug increased from 3% in 2002/3 to 5% in 2006/7. There was a slight increase in lifetime use of ecstasy, and use of amphetamines remained stable.

Opiate situation in Ireland

Ireland, like over half of the countries in the EU, reported an increase in new opiate cases entering treatment since 2005. After a decrease between 2001 and 2004, the number of such cases increased steadily between 2005 and 2007, when 9,769 cases received substitution treatment for opiate use. Problem opiate (mostly heroin) use accounted for 63% of those entering treatment for drug problems in Ireland, compared to the European average of 47%.

In 2005, 159 drug-induced deaths occurred in Ireland and 88% of fatal overdoses were associated with opiate use. The number of such deaths increased in Ireland in 2004 and 2005, as they did in most European countries. Research in Ireland, Spain, the UK and elsewhere shows that the risk of overdose decreases substantially when heroin users are in substitution treatment. While there has been a dramatic expansion of methadone treatment services in Europe, and the treated population has grown steadily, the number of methadone-related deaths has fallen.

With regard to infectious diseases, the Health Protection Surveillance Centre reported that there were 1,381 diagnosed HIV cases in Ireland at the end of 2007, probably infected through injecting drug use. Data from blood-borne viral prevalence studies completed between 1995 and 2001 indicated that around 10% of injecting drug users attending drug treatment tested positive for antibodies to HIV and 70% for antibodies to hepatitis C; this places Ireland among the low-prevalence countries for HIV and among the high-prevalence countries for hepatitis C.

The number of heroin seizures in Ireland increased from 612 in 2004 to 763 in 2005, and, more sharply, to 1,254 in 2006 and to 1,698 in 2007; the latter increase is higher than the 10% increase between 2006 and 2007 in heroin seizures reported in some European countries.

Cocaine situation in Ireland

The proportion of adults in Ireland who reported using cocaine (including crack) at some point in their lives increased from 3% in 2002/3 to 5% in 2006/7; the figures for young adults also showed an increase, from 5% in 2002/3 to 8% in 2006/7. The proportion of young adults who reported using cocaine in the last year increased from 2% in 2002/3 to 3% in 2006/7; the range for current cocaine use among young adults in Europe was between 0.2% and 5.4% placing Ireland among the high-prevalence countries (such as the UK, Spain and Italy).

Like Ireland, many countries across Europe reported an increased demand for treatment for problem cocaine use. The number of treated cases in Ireland who reported cocaine as a main problem drug increased considerably, from 81 in 2001 to 770 in 2007; in 2007, 462 cases entered treatment for the first time. In 2007, cocaine use (mostly powder) accounted for 13% of those who entered treatment for drug problems in Ireland, compared to an average of 16% across Europe. The number of cocaine seizures in Ireland has increased with time, from 515 in 2003 to 1,749 in 2007.

Amphetamines, ecstasy

Amphetamine use is relatively uncommon in this country and Ireland is among the low-prevalence countries in Europe. Ecstasy use is more common than amphetamine use among young adults in Ireland. The proportion of young adults who reported using ecstasy in the last year remained relatively stable at 2.3% in 2002/3 and 2.4% in 2006/7, which places Ireland among the medium-prevalence countries. The number of treated cases who reported ecstasy as a main problem drug decreased considerably, from 219 in 2001 to 129 in 2007.

Cannabis

Cannabis was the most commonly used illegal drug in Ireland and its use has not declined as it has in other parts of Europe. The proportion of adults who reported using cannabis at some point in their life increased from 17% in 2002/3 to 22% in 2006/7 and the proportion who used it in the last year increased from 5% in 2002/3 to 6.3% in 2006/7, placing Ireland just below the EU average (7%). However, the number of treated cases reporting cannabis as a main problem drug decreased steadily. In 2007, cannabis use accounted for 16% of those entering treatment for drug problems in Ireland, compared to an average of 21% across Europe. Cannabis seizures account for the majority of all drug seizures in Ireland.

(Brian Galvin)

1. EMCDDA (2009) *Annual report 2009*: *the state of the drugs problem in Europe.* Luxembourg: Office for Official Publications of the European Communities. www.emcdda.europa.eu/publications/annual-report/2009

British–Irish Council summit discusses illicit drugs

On 13 November 2009 the British–Irish Council (BIC) held its 13th summit meeting. The Irish Government delegation was led by An Taoiseach Brian Cowen TD, and included Éamon Ó Cuív TD, Minister for Community, Rural and Gaeltacht Affairs. The Council noted that the Sectoral Group on the Misuse of Drugs held three meetings during 2009.

1. In March, Guernsey briefed the group on the introduction of its new legislation to ban 'Spice' and other psychoactive substances. The aim of this legislation is to disrupt the commercial importation and sale of such substances (as opposed to criminalising users). The issue of 'Spice' and 'legal highs' has now come to prominence at EU level. Given the ongoing developments, the BIC Sectoral Group is in agreement that the issue should remain as a standing agenda item for discussion in future meetings.
2. In May, Dr Suzi Lyons of the Alcohol and Drug Research Unit of the Health Research Board gave a presentation to the group on the development and the content of the country's National Drug-Related Deaths Index, which was launched in late 2008. The Index gives Ireland an accurate picture of the levels of drug-related deaths, thus facilitating policy development in the drugs area.
3. A meeting held in September focused on prevention and how Scotland was raising awareness among the overall population of the dangers of drug use through their national *Know the Score* campaign.

The next ministerial meeting will be held in 2010 and ministers will discuss substance misuse in the prison setting and the responses necessary to address this issue, along with how best to provide effective treatment and rehabilitation options to this cohort. For further information visit www.british-irishcouncil.org

Participation in international drugs policy arena will add value to Ireland's drugs strategy

The new National Drugs Strategy for 2009–2016 (NDS) includes a blueprint for enhancing Ireland's role in the international drugs policy arena.[1] The Steering Group that drafted the NDS states: 'Properly co-ordinated international co-operation can, and will, add value to the new NDS'.

For the first time Ireland's responses to developments in international drugs policy will be centrally co-ordinated, by the newly established Office of the Minister for Drugs (OMD). The Steering Group observes, 'Given that virtually all the relevant government departments will be represented in the new Office, such co-ordination should be easier to achieve and should become an on-going feature of their work'. Specific co-ordinating tasks will include:

- circulation of draft speeches and briefings to be presented internationally among relevant government departments for prior observations and comment;
- quarterly meetings of key officials from the relevant government departments, or as the need arises;
- annual meeting chaired by the Minister for Drugs to plan Ireland's broad approach across the various issues and fora; and
- regular six-monthly updates at the Official Forum for Drugs (OFD), or as the need arises.

The value to be gained from more effective co-ordination, according to the Steering Group, will derive partly from enhancing the effectiveness of efforts to address the drugs problem at international level and thereby increasing public safety, and partly from providing opportunities to share experiences with, and learn from, other countries. Minister for Drugs John Curran TD described the value to be gained from participating in EU and international drug policy fora as being 'the ability to monitor trends, tackle supply reduction and learn from the successes and failures of drugs policies implemented by other countries'.[2]

Table 6.5 of the new NDS lists eight 'key EU and other groups and committees' on which Ireland is represented and the government departments and agencies which attend these meetings. The roles of these bodies are outlined in Table 1 (overleaf). It is through work on these groups and committees that the anticipated additional value may be expected to be delivered. The work of these bodies will, in turn, be driven by the goals and objectives agreed at international and national level, which are listed in Table 2 (overleaf).

(Brigid Pike)

1. Department of Community, Rural and Gaeltacht Affairs (2009) *National Drugs Strategy (interim) 2009–2016*. Dublin: Department of Community, Rural and Gaeltacht Affairs. paras 6.92–6.100.
2. Curran J (2009) 'Yes to Lisbon no to drugs'. Open letter. Accessed 20 October 2009 at www.johncurrantd.com/?id=95

Participation in international drugs policy arena *(continued)*

Table 1 Key EU and other international drug policy groups and committees on which Ireland is represented

Horizontal Working Party on Drugs (HDG)	The HDG is the European Council's working party tasked with leading and managing the Council's work on drugs. Meeting monthly, the HDG's work covers all policy areas, and relevant working parties (including the Police Cooperation Working Party, the Customs Cooperation Working Party, the Multidisciplinary Group on Organised Crime, the Working Party on Public Health, and External Relations Working Parties) report to the HDG on their drug-related work. The task of leading and managing the work on drugs is performed both by the HDG itself and through drug troikas with third countries. The work programme is based on the EU Drugs Action Plan, which in turn is based on the EU Drugs Strategy.
Commission on Narcotic Drugs (CND)	The CND is the central policy-making body of the United Nations in drug-related matters. Meeting once a year, the CND enables member states to analyse the world drug situation, and develops proposals to strengthen the international drug control system to combat the world drug problem. www.unodc.org/unodc/en/commissions/CND/index.html
European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)	The EMCDDA provides the EU and its member states with a factual overview of European drug problems and a common information framework to support the drugs debate. To realise its purpose, the EMCDDA coordinates and relies on a network of some 30 national monitoring centres (Reitox network) to gather and analyse country data according to common data-collection standards and tools. In Ireland, the Health Research Board is currently the national monitoring centre. The results of this national monitoring process are fed to the EMCDDA in Lisbon for analysis and are ultimately released in the EMCDDA's annual report on the state of the drugs problem in Europe. www.emcdda.europa.eu
Pompidou Group	The Co-operation Group to Combat Drug Abuse and Illicit Trafficking in Drugs (Pompidou Group) is incorporated in the institutional framework of the Council of Europe and comprises 35 member states, including Ireland. It provides a multidisciplinary forum where policy-makers, professionals and researchers can discuss and exchange information and ideas on the whole range of drug misuse and trafficking problems. The Pompidou Group's work programme is organised around six platforms – prevention, treatment, criminal justice, research, ethics and airports. www.coe.int/T/dg3/pompidou/
EU National Drug Co-ordinators Network	Broad policy issues are considered twice yearly by the EU Drug Co-ordinators Network. To date, officials in the National Drugs Strategy Unit in the Department of Community, Rural and Gaeltacht Affairs have represented Ireland on this network.
British–Irish Inter-sectoral Group on Drugs	Ireland has lead responsibility for advancing work with regard to tackling the misuse of drugs among the nine jurisdictions represented on the British–Irish Council. Information and experience of best practice in relation to topics ranging across both supply and demand reduction are shared at the meetings of ministers and of officials. Professionals and academics in the relevant field also attend the meetings. www.british-irishcouncil.org
Civil Society Forum on Drugs	Established in 2007 by the European Commission, the Civil Society Forum on Drugs meets at least once a year and serves as a platform for informal exchanges of views and information between the European Commission and civil society organisations in the EU. Membership is for a period of two years and at present 26 organisations are members of the Forum. The overall objective of the Forum is to feed specific grass-roots experience into future Commission proposals, and also into the work of monitoring the EU action plan on drugs. http://ec.europa.eu/justice_home/fsj/drugs/forum/fsj_drugs_forum_en.htm
Multidisciplinary Group on Organised Crime (MDG)	The MDG is a working party of the European Council, originally set up in 1997 to support implementation of the EU's action plan on organised crime. Meeting monthly, the purpose of the MDG is to draw up guidelines for co-ordinating the fight against organised crime. It also deals with various other questions concerning organised crime.

Participation in international drugs policy arena *(continued)*

Table 2 Key dates in formulation and implementation of international illicit drugs strategies and action plans, and Ireland's NDS, 2009–2019

Year	United Nations	European Union	Ireland
2009	• Political Declaration adopted at 52nd Session of CND • 10-year Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem, adopted in conjunction with the new Political Declaration	• EU Drugs Action Plan 2009–2012 published (to support implementation of the 7-year EU Drugs Strategy 2005–2012)	• National Drugs Strategy (interim) 2009–2016 launched
2012		**Target date to achieve:** 1. measurable reduction of the use of drugs, of dependence and of drug-related health and social risks; and 2. measurable improvement in the effectiveness, efficiency and knowledge base of law enforcement interventions and actions by the EU and its member states targeting production, trafficking of drugs, the diversion of precursors, including the diversion of synthetic drug precursors imported into the EU, drug trafficking and the financing of terrorism, money laundering in relation to drug crime.	
2013		New EU Drugs Strategy and Action Plan?	Mid-Term Review of National Drugs Strategy?
2014	• CND to conduct high-level review of implementation of 2009 Political Declaration and Action Plan • Economic and Social Council to devote a high-level segment to a theme related to the world drug problem • General Assembly to hold a special session to address the world drug problem		
2016			**Target date to:** • create a safer society through the reduction of the supply and availability of drugs for illicit use; • minimise problem drug use throughout society; • provide appropriate and timely substance treatment and rehabilitation services (including harm reduction services) tailored to individual needs; and • ensure the availability of accurate, timely, relevant and comparable data on the extent and nature of problem substance use in Ireland.
2017			New National Drugs Strategy?
2019	**Target date to eliminate or reduce significantly and measurably:** 1. illicit cultivation of opium poppy, coca bush and cannabis plant; 2. illicit demand for narcotic drugs and psychopathic substances, and drug-related health and social risks; 3. illicit production, manufacture, marketing and distribution of, and trafficking in, psychotropic substances and synthetic drugs; 4. diversion of and illicit trafficking in precursors; and 5. money laundering related to illicit drugs.		

Bridging the research gap in the field of illicit drugs

The European Commission hosted a conference titled 'Bridging the research gap in the field of illicit drugs in the EU' in Brussels on 24–25 September 2009.

At the conference, Dr Gerhard Bühringer and Dr Michael Farrell presented a mapping of drug-related research in the EU, based on their work for a report recently published by the European Commission.[1] They documented the existence of both projects and research publications on illicit drugs. The projects and publications were classified into five themes: understanding drug-use behaviour, demand reduction, supply reduction, policy analysis and meta-evaluations. The mapping process identified that half of the projects examined the epidemiology of drug use and 30% tested a prevention or treatment intervention. There were very few projects on drug supply.

Ireland had 22 research projects between 2001 and 2006 and 66 publications in the four years 2001/2 and 2005/6. The majority of these projects and publications covered the epidemiology of drug use.

Mr Wolfgang Gotz, Director of the EMCDDA, mentioned two challenges to bridging the gap between research and policy: the dearth of longitudinal studies and the need to improve methods of dissemination.

There were three parallel sessions: connecting research policy and drug policy, gaps in current knowledge, and funding mechanisms in different EU countries. These sessions were carried over to the following day. In addition, delegates from Australia, Canada and the US shared their experiences of illicit drug research in their countries and of getting the findings into policy and practice.

(Jean Long)

1. Bühringer G, Farrell M, Kraus L, Marsden J, Pfeiffer-Gerschel T, Piontek D *et al.* (2009) *Comparative analysis of research into illicit drugs in the European Union.* Brussels: European Commission, Directorate-General for Justice, Freedom and Security.

Putting research evidence into practice

In 1998 the US Institute of Medicine published a landmark report on bridging the gap between practice and research in community-based drug and alcohol treatment.[1] Subsequently, EU Action Plans 2000–2004,[2] 2005–2008[3] and 2009–2012[4] called on EU member states to promote and disseminate evidence-based practice interventions to reduce demand for drugs. The recently published *National Drugs Strategy (interim) 2009–2016*[5] notes that

> a significant body of knowledge on evidence-based best practice in relation to dealing with problem drug use has been built up. However, a key challenge is to disseminate best practice among service providers to ensure that it is applied. (S. 5.41).

This article presents the findings from a recent systematic review that evaluated the effectiveness of opinion leaders in changing practitioners' behaviour, and sought to determine how this strategy might be used to bridge the research-to-practice gap in the alcohol and other drugs (AOD) field.[6] This work formed part of a larger systematic review to evaluate the effectiveness of a range of implementation strategies. In their report on the larger review, the authors state that 'the rationale behind the use of opinion leaders as an educational strategy is that new information will be integrated more efficiently into practice if a respected peer trains a practitioner'.[7]

The authors define an opinion leader as an educationally influential individual who is (i) a recognised expert in their field; (ii) more likely than others to facilitate the flow of new information; and (iii) has well-developed interpersonal skills. Also known as change agents and knowledge brokers, opinion leaders interpret the meaning of technically or conceptually difficult information for standard users.

Methods

They authors undertook a systematic review of the literature covering the period from 1966–March 2005, using a wide range of electronic databases, relevant websites and hand-searching of reference lists. Inclusion criteria limited the review to controlled studies that collected baseline data and had a study period of at least three months. Outcome measures included process outcomes to assess utilisation of the innovation, e.g. changes in health care professionals' behaviour, and patient outcomes to assess the impact of the innovation on patients' health status. The quality of the studies was assessed on three domains, strength and relevance of the evidence and size of the effect, and was rated as good, average or poor.

Results

Four papers met the inclusion criteria for this review – one good-quality systematic literature review comprising eight randomised controlled trials, and three good-quality primary studies. A qualitative synthesis of the data was undertaken, as, due to the heterogeneity of the studies, a meta-analysis was not possible as no common measure of effect was considered justified. Since none of the included studies were conducted in the AOD context, evidence is based on results from studies of health care professionals, e.g. physicians, nurses and surgeons. The studies used opinion leaders primarily to improve adherence to guidelines for management of various chronic conditions, e.g. asthma, heart disease and arthritis, which, according to the authors, have important parallels in management of AOD-related problems.

Putting research evidence into practice *(continued)*

Overall, opinion leaders in the 11 studies identified showed variable effectiveness in changing professional practice. Levels of effectiveness varied from not significant to small-to-modest in some process outcomes in the better-quality studies; process outcomes assessed changes in the behaviour of health professionals. Overall, patient outcomes were not significantly improved by the use of opinion leaders. The authors conclude: 'While it may make intuitive sense for the use of well-respected peers to disseminate innovations, current evidence is sparse and inconsistent and fails to support the use of opinion leaders as change agents. These equivocal results may reflect the heterogeneity across studies.'

(Martin Keane)

1. Institute of Medicine (1998) *Bridging the gap between practice and research: forging partnerships with community-based drug and alcohol treatment.* Washington DC: National Academy Press.
2. Council of the European Union (2000) *EU Action Plan on Drugs 2000–2004.* Brussels: Council of the European Union.
3. Council of the European Union (2005) *EU Action Plan on Drugs 2005–2008.* Brussels: Council of the European Union.
4. Council of the European Union (2009) *EU Action Plan on Drugs 2009–2012.* Brussels: Council of the European Union.
5. Department of Community, Rural and Gaeltacht Affairs (2009) *National Drugs Strategy (interim) 2009–2016.* Dublin: Department of Community, Rural and Gaeltacht Affairs.
6. Bywood P, Lunnay B and Roche A (2009) Effectiveness of opinion leaders for getting research into practice in the alcohol and other drugs field: results from a systematic literature review. *Drugs: education, prevention and policy,* 16(3): 205–216.
7. Bywood P, Lunnay B and Roche A (2008) *Effective dissemination: a systematic review of implementation strategies for the AOD field.* Adelaide: National Centre for Education and Training on Addiction. p. 44.

Problem opiate use in Ireland

An opiate is a drug containing opium or any of its derivatives which acts as a sedative and narcotic. Examples include heroin, methadone, morphine, codeine, hydrocodone, oxycodone, fentanyl and tramadol. Heroin is synthesised from morphine, a naturally occurring substance extracted from the seed pod of the Asian opium poppy plant.[1] Heroin is available in three forms – a white powder, a brown powder or a black sticky substance, known as 'black tar heroin'.

Data sources

In a repeat of a similar prevalence study in 2001–2001,[2] Dr Alan Kelly and colleagues estimated the prevalence of problem opiate users in Ireland in 2006 using a three-source capture-recapture method.[3] The three data sources used were the Central Treatment List (of clients on methadone), the Hospital In-Patient Enquiry scheme and the Garda PULSE data. This article highlights some of the study findings and presents data from the National Drug Treatment Reporting System (NDTRS),[4] the National Drug-Related Deaths Index (NDRDI)[5] and the Central Statistics Office (CSO).[6]

Estimation of the numbers of adult problem opiate users

Data from the three sources indicated that there were 11,807 opiate users aged 15–64 years known to services in Ireland in 2006, and an estimated 8,983 users not known to the services (hidden population) (Table 1). The national prevalence estimate of opiate users in 2006 was between 18,136 and 23,576; the point estimate was 20,790 (Table 2). This estimate is likely to be inflated (see footnote).[7] Twenty-eight per cent (5,886) of the estimated number lived outside Dublin and 72% (14,904) lived in Dublin. The respective rates per 1,000 of the 15–64-year-old population in Dublin and in the rest of Ireland are 17.6 and 2.9.

Table 1 Number of opiate users known, estimated number hidden, prevalence estimate and population rate in Ireland, in Dublin and in the rest of Ireland, 2006

	Age group	Known number	Estimated hidden number	Estimated prevalence	Rate/1,000 population
Ireland	15–64	11,807	8,983	20,790	7.2
Dublin	15–64	9,442	5,462	14,904	17.6
Rest of Ireland	15–64	2,365	3,521	5,886	2.9
Source: Kelly *et al.* (2009)					

Table 2 Estimated prevalence of opiate use in Ireland, in Dublin, and in the rest of Ireland, 2001 and 2006

	2001				2006			
	Estimate	Lower bound	Upper bound	Rate/1000 population	Estimate	Lower bound	Upper bound	Rate/1000 population
Ireland	14,681	13,405	15,819	5.6	20,790	18,136	23,576	7.2
Dublin	12,456	11,519	13,711	15.9	14,904	13,737	16,450	17.6
Rest of Ireland	2,225	1,934	2,625	1.2	5,886	4,399	7,126	2.9
Source: Kelly *et al.* (2003, 2009)								

Problem opiate use in Ireland *(continued)*

The point estimate increased by 42%, from 14,681 in 2001 to 20,790 in 2006. The point estimate for Dublin increased by 20%, while the point estimate for the rest of Ireland increased by 165% – albeit from a low estimate in 2001. The rate of opiate use per 1,000 of the 15–64-year-old population living outside Dublin increased from 1.2 in 2001 to 2.9 in 2006.

Table 3 shows the 2006 estimate by age, gender and place of residence. Seventy-one per cent were male. One in five (21%) was between 15 and 24 years old and half (51%) were between 25 and 34 years old. In Dublin, the rate of opiate use per 1,000 of the 15–24-year-old female population decreased by 62%, from 18.7 in 2001 to 7.2 in 2006, which indicates that the number of younger women commencing opiate use has decreased. A smaller but still notable decrease in the rate of opiate use in Dublin was seen among males aged 15–24 years.

Table 3 Prevalence estimate by age, gender and place of residence, 2006

Gender	Age group	Ireland	Dublin	Rest of Ireland
All	15–64	20,790	14,904	5,886
Males	15–64	14,787	10,395	4,392
	15–24	3,150	1,892	1,258
	25–34	7,238	5,172	2,066
	35–64	4,399	3,331	1,068
Females	15–64	6,003	4,509	1,494
	15–24	1,159	701	458
	25–34	3,298	2,605	693
	35–64	1,546	1,203	343

Source: Kelly *et al.* (2009)

In an unpublished study, Kelly and colleagues report that retaining opiate users in treatment reduces their likelihood of being in contact with the gardaí (Dr A Kelly, personal communication, 2009). For example, only 12% of males aged 25–34 years who were known to the gardaí in 2001 and were attending treatment services between 2001 and 2006 were reported to be committing crime in 2006. This is in line with findings from the ROSIE study[8] and indicates that methadone treatment reduces the incidence of crime.

NDTRS data – treated opiate users

In 2007, 11,538 cases were treated for problem opiate use.[4] This is a 31% increase (2,734 cases) since 2002 and an increase of just over 7% (783 cases) since 2006 (Table 4).

- Two-thirds (7,643) of problem opiate users were continuing in care, that is, they were already in methadone treatment on 31 December 2006 and continued to receive that treatment after 1 January 2007.
- Just over one-fifth (2,598) had received treatment before and re-entered treatment in 2007. This reflects the fact that problem opiate use is a recurring problem and requires repeated treatment over time.
- Ten per cent (1,151) were new cases presenting for treatment for the first time.
- A small number of cases (146, 1.3%) were not clearly identified as either new or return cases.

Of the 3,575 previously treated and new cases who entered treatment in 2007 and who reported opiates as their main problem substance, more than half used it daily, 10% used it on two to six days per week and 6% used it once a week or less. One-quarter had not used it in the month prior to treatment; this reflects the transfer of stable clients to other types of treatment centres, such as general practice and medication-free residential services.

Between 2002 and 2007, 5,304 cases entered treatment for the first time. The rate of new cases aged 15–64 increased from 28 per 100,000 in 2002 to 35 in 2007. The overall number of opiate cases was high in Dublin; however, the number of new cases was lower in 2007 than in 2002. Over the same period there was a significant increase in new cases elsewhere in the country, with a steady increase in the midland, south eastern and north eastern counties. The number of new cases is an indirect indicator of recent trends in problem substance use.

There was a 54% (2,680) increase in the number of methadone treatment places between 2001 and 2007. This reflects one of the benefits of the proactive approach of the National Drugs Strategy. It is important to note that methadone substitution is a long-term treatment that can take a number of years to show results.

Of the 3,575 cases who entered treatment and reported opiates as their main problem substance in 2007, 52% smoked it, 40% injected it and 5% consumed it orally. From 2003 to 2007, decreasing proportions of cases reported injecting as their primary route of administration, while correspondingly increasing proportions reported smoking as their primary route.

The proportion of cases treated for opiates as a main problem substance who reported use of more than one substance decreased from 69% in 2002 to 63% in 2007. The decrease in polydrug use was observed among both

Table 4 Opiate cases in treatment, by treatment status (NDTRS 2002–2007)

	2002	2003	2004	2005	2006	2007
	Number (%)					
All cases	8804	9113	9542	10217	10755	11538
Continuous care cases	5601 (63.3)	5944 (65.2)	6433 (67.4)	6924 (67.8)	7269 (67.6)	7643 (66.2)
Cases entering treatment	3203 (36.4)	3169 (34.8)	3109 (32.6)	3293 (32.2)	3486 (32.4)	3895 (33.8)
Of which:						
Previously treated cases	2252 (25.6)	2280 (25.0)	2265 (23.7)	2395 (23.4)	2352 (21.9)	2598 (22.5)
New cases	809 (9.2)	808 (8.9)	737 (7.7)	803 (7.9)	996 (9.3)	1151 (10.0)
Treatment status unknown*	142 (1.6)	81 (0.9)	107 (1.1)	95 (0.9)	138 (1.3)	146 (1.3)

*Relevant data not recorded on the NDTRS form returned.

Problem opiate use in Ireland *(continued)*

new and previously treated opiate cases, but was more marked among the new cases. The reason for the decrease is not clear; it may be the result of an increase in the number of newer opiate users who have yet to develop chronic polydrug-using practices, or of improved history-taking practices by service providers. Polydrug use is one of the factors that can impede successful treatment for problem opiate use. Specific interventions, such as detoxification from other drugs and contingency management, are required to address this problem.

Table 5 shows the additional problem substances used by cases entering treatment who reported opiates as their main problem substance. Between 2002 and 2007, cannabis, benzodiazepine and cocaine were the most common additional problem substances reported. Cannabis was top of this list in each of the six years. Benzodiazepine was the second most common additional substance between 2002 and 2005, but was replaced by cocaine in 2006 and 2007.

The number reporting cocaine as an additional problem substance increased by 59% over the period. The number reporting alcohol as an additional problem substance increased by 250% over the period.

NDRDI data – deaths among opiate users

The NDRDI reported that there were 1,553 deaths as a result of poisoning between 1998 and 2005.[5] In over half (839, 54.0%) of these deaths, heroin, methadone or other opiates were implicated (either alone or in conjunction with other substances) (Table 6). Over one-third (292, 34.8%) of the opiate-related deaths were attributable to a single opiate. Of all the poisoning cases involving an opiate, 634 (75.6%) were male and 657 (78.3%) were aged between 20 and 44 years; of those for whom employment status was known, 445 (62.4%) were unemployed.

Table 5 Additional problem substances used by cases entering treatment* who reported opiates as a main problem substance (NDTRS 2002–2007)

	2002	2003	2004	2005	2006	2007
Additional problem substances used†	Number (%)					
All cases	2114	2138	1932	2120	2261	2239
Cannabis	1075 (50.9)	1115 (52.2)	934 (48.3)	1060 (50.0)	1194 (52.8)	1106 (49.4)
Benzodiazepine	1005 (47.5)	909 (42.5)	785 (40.6)	875 (41.3)	936 (41.4)	788 (35.2)
Cocaine	609 (28.8)	782 (36.6)	752 (38.9)	811 (38.3)	966 (42.7)	969 (43.3)
Opiates‡	598 (28.3)	559 (26.1)	550 (28.5)	560 (26.4)	572 (25.3)	443 (19.8)
Alcohol	153 (7.2)	246 (11.5)	245 (12.7)	332 (15.7)	457 (20.2)	536 (23.9)
Ecstasy	255 (12.1)	225 (10.5)	152 (7.9)	169 (8.0)	134 (5.9)	140 (6.3)
Amphetamines	59 (2.8)	47 (2.2)	31 (1.6)	23 (1.1)	40 (1.8)	45 (2.0)
Volatile inhalants	10 (0.5)	6 (0.3)	7 (0.4)	6 (0.3)	4 (0.2)	6 (0.3)
Other substance	57 (2.7)	48 (2.2)	49 (2.5)	45 (2.1)	37 (1.6)	50 (2.2)

*Excludes cases not normally resident in Ireland.

†By cases reporting use of one, two or three additional substances.

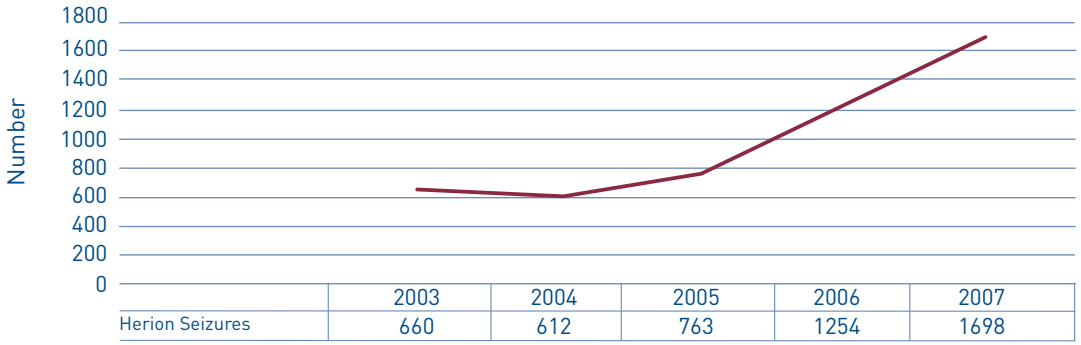
‡Cases may report one type of opiate as their main problem substance and another type of opiate as an additional problem substance.

Table 6 Number of poisoning deaths in which opiates were implicated (NDRDI 1998–2005)

	1998	1999	2000	2001	2002	2003	2004	2005
All poisoning deaths	178	187	182	175	210	184	205	232
Poisoning deaths involving an opiate	95	102	104	98	112	93	110	125
By category:								
Opiate (excluding analgesic containing an opiate compound)	72	81	71	71	79	63	74	93
Opiate alone (excluding methadone)	12	22	17	29	15	16	22	22
Methadone alone	8	7	6	7	6	6	11	10
Analgesic containing an opiate compound (alone)	9	5	13	11	9	8	12	9
Opiate with other substance(s)	52	52	48	35	58	41	41	61
Analgesic containing an opiate compound with other substance(s)	14	16	20	16	24	22	24	23

Source: Unpublished data from the NDRDI.

Problem opiate use in Ireland *(continued)*



	2003	2004	2005	2006	2007
Herion Seizures	660	612	763	1254	1698

Figure 1 Trend in the number of heroin seizures 2003–2007 (CSO 2008, 2009).

CSO data – drug seizures

Figure 1 presents the number of heroin seizures in the years 2003–2007, showing a steady rise since 2004.

Conclusion

The data from a range of sources indicate an increase in opiate availability, and a parallel increase in use and in treatment demand. The data also point to the serious consequences of opiate use, most notably the considerable number of deaths each year in which an opiate is involved.

(Jean Long and Suzi Lyons)

1. National Institute on Drug Abuse (2009) *NIDA InfoFacts: opiates.* Accessed 11 November 2009 at: http://www.nida.nih.gov/infofacts/heroin.html
2. Kelly A, Carvalho M and Teljeur C (2003) *Prevalence of opiate use in Ireland 2000–2001: a 3-source capture-recapture study.* Dublin: Stationery Office.
3. Kelly A, Carvalho M and Teljeur C (2009) *Prevalence of opiate use in Ireland 2006: a 3-source capture recapture study.* Dublin: National Advisory Committee on Drugs.
4. Carew AM, Bellerose D, Lyons S and Long J (2009) *Trends in treated problem opiate use in Ireland, 2002 to 2007.* HRB Trends Series 7. Dublin: HRB.
5. Lyons S, Lynn E, Walsh S and Long J (2008) *Trends in drug-related deaths and deaths among drug users in Ireland, 1998 to 2005.* HRB Trends Series 4. Dublin: HRB.
6. Central Statistics Office (2009) *Garda recorded crime statistics 2003–2007.* Dublin: Stationery Office.
7. These estimated figures are likely to be inflated because the population was not closed, that is, it continued to recruit significant numbers of people into treatment (in Dublin and outside Dublin) and police custody (outside Dublin) in 2006. In addition, the overlap between the three population sources was small. These two factors are known to inflate estimates obtained by the capture-recapture method.
8. Cox G, Comiskey C and Kelly P (2007) *ROSIE Findings 4: summary of 1-year outcomes: methadone modality.* Dublin: National Advisory Committee on Drugs.

Solvent and volatile inhalant use in Ireland

Under the Irish Child Care Act 1991 it is an offence to sell, offer or make available solvents to a person aged 17 or under if there is reasonable cause to believe that he/she is likely to inhale them.

Solvents or volatile inhalants are a diverse group of substances whose chemical vapors can be inhaled to produce psychoactive or mind-altering effects.[1] These substances vaporise at room temperature. A variety of products common in the home, school and workplace contain volatile substances that can be inhaled (Table 1); however, people do not typically think of these products as drugs because they were never intended to induce intoxicating effects. Yet, young children and adolescents can easily obtain these toxic substances and are among those most likely to abuse them.

NACD general population survey – volatile inhalant use

According to the 2006/7 survey,[2] the proportion of the adult population who reported using a solvent or volatile inhalant in their lifetime was 1.9%, a small increase on the 2002/3 figure of 1.7%. It was more common for men (2.3%) than women (1.4%) to report use of these substances. Lifetime use was highest among adults aged 15–24 years, at 4.2%.

Survey of school children – volatile inhalant use

A study completed in 2004 examined the extent of tobacco, alcohol and drug use among primary school children aged 11 to 14 years in Limerick City, Limerick County, Clare and North Tipperary (the Mid-West Region).[3] Of the 1,254 respondents to the survey questionnaire, 53 (4.2%) had used glue/solvents at least 'once or twice' in their lives. Forty-four out of the 53 said that they had only ever done this 'once or twice'. Thirty-three of the solvent users were male and 20 were female.

The fourth ESPAD survey[4] was conducted in 35 European countries during 2007 and collected information on alcohol and illicit drug use among 15–16-year-olds. Lifetime use of solvents or inhalants decreased in Ireland over three time points, from 22% in 1999 to 18% in 2003 and to 15% in 2007, but remained higher than the European average (9%).

Solvent and volatile inhalant use in Ireland *(continued)*

Table 1 Type, descriptor and examples of volatile inhalants and solvents

Type	Descriptor	Examples
Volatile solvents	Liquids that vaporise at room temperature. Found in a multitude of inexpensive, easily available products used for common household and industrial purposes	Paint thinners and removers Dry-cleaning fluids, Degreasers Gasoline, Glues Correction fluids Felt-tip marker fluids
Aerosols	Sprays that contain propellants and solvents	Spray paints Deodorants, Hairsprays Vegetable oil sprays Fabric protector sprays
Gases	Medical anesthetics as well as gases used in household or commercial products	Butane lighters, Propane tanks Whipped cream dispensers Refrigerants Chloroform, Ether, Halothane Nitrous oxide (laughing gas)
Nitrites	Nitrites, unlike most other inhalants, act primarily to dilate blood vessels and relax the muscles. While other inhalants are used to alter mood, nitrites are used primarily as sexual enhancers	Amyl nitrite Butyl nitrite

Source: US National Institute on Drug Abuse (2007).

Girls were marginally more likely to have used solvents or inhalants than boys, 16% compared to 14%. Half of the users reported that they had taken these substances three or more times during their life.

Volatile inhalant use among young people in the south east of Ireland

A recent study explored practices, social dynamics and effects of solvent or volatile inhalant use and suggested methods to deter or stop use among young people.[5] This inquiry was part of a much larger study on drug use. The authors interviewed 11 males and nine females (average age 13.2 years) living in the south-east of Ireland about their solvent or volatile inhalant use. The average age of first solvent use was 10.3 years; frequency of subsequent use was sporadic and opportunistic and most stopped using by the age of 13 years. Half of the solvent users also smoked cigarettes, despite the obvious danger associated with co-use. Solvent use was followed by initiation into alcohol use (average age of first use 12.5 years) and then a small number experimented with cannabis. Most used solvents outdoors with their peer group and during the summer holidays. There were some reports of solvent use during school breaks.

The type of solvent used was determined by cost, access and place of residence. Children who lived in rural areas used a limited number of products, namely, wood glue, diesel and petrol, whereas children in urban areas used a wide variety of products, including Pritt Stick, methylated spirits, hairspray, deodorant, chrome paint, butane, nitrous oxide and Vicks nasal inhalant. Some products were inhaled using a plastic bag, others by placing the spray nozzle in the mouth or nostril, and others by pouring the product on a damp cloth and placing it over the face. Participants reported a variety of reasons for continuing to use solvents, such as to be part of the peer group, to relieve boredom, to experience a high, to help to deal with stress or to escape from reality. They reported a variety of physical effects such as fainting, vomiting, inflamed nostrils or headache. Some reported doing things following use that they would not normally do, such as having sex, being involved in vandalism or acting on a dare. All respondents knew someone who had died as a result of solvent use. In general, they reported that teachers were uncomfortable delivering information about drug use. They suggested that shopkeepers should not sell these substances to children. They also suggested that use would be deterred if the negative effects of these substances were explained and life stories were shared. The latter suggestion is not in line with the current evidence-based practice.

NDTRS data – treated volatile inhalant users (unpublished data)

The numbers who entered treatment in the years 2003–2007 and reported solvents or volatile inhalants as their main problem substance ranged between 24 and 32, with a total of 137 for the five-year period. The vast majority (112) of these cases were entering drug treatment for the first time. Just over half (53%) were male and four-fifths were aged 17 years or under. Only 13% lived in Dublin (possibly an indication of service availability in Dublin) and 70% were still in school. The vast majority (97%) were Irish. The solvents or volatile inhalants most commonly reported as a main problem substance were solvents (reported by 78 cases), nitrites (by 16), petrol (by 12) and butane (by 7), and the most common additional problem substances were alcohol and cannabis. In the same five-year period 164 cases reported solvents or volatile inhalants as an additional problem substance, of whom 106 were treated for the first time.

Solvent and volatile inhalant use in Ireland *(continued)*

NDRDI data – deaths as a result of volatile inhalant use

The NDRDI reported 1,553 poisoning deaths in the period 1998–2005.[6] Volatile inhalants and solvents were implicated in 30 of these deaths (Table 2), of which 22 were in the under-20 age group, with nine of these in the under-15 age group. Only a small number of these individuals were known to be in drug treatment at the time of their death. More than one substance was implicated in 20% of the deaths; the other substances involved were other solvents, opiates, antidepressants, benzodiazepines and alcohol. The annual death rate remained reasonably steady over the eight-year period. The male to female ratio was approximately equal (at 1.1:1). The majority (76.6%) of these individuals, including all of the under-15s, were not alone at the time of their death, and 56.6% of the deaths occurred in a private dwelling.

Table 2 Volatile substances implicated in poisoning deaths (NDRDI 1998–2005, unpublished data)

Volatile substance	Number of deaths
Butane, propane	12
Other substance (lighter fluid, glue, industrial solvent, Freon, helium, aerosol spray)	10
Antiperspirant	8
Total	30

Conclusion

The majority of volatile inhalant or solvent users are teenage boys and girls who are still in school. Only a small number seek treatment for problematic use of these substances. Nonetheless, there are a number of fatalities each year as a result of inhaling these everyday household products.

In early 2006, the Justice Department of the Scottish Executive commissioned a review of the available evidence on volatile substance abuse among young people in Scotland.[7] The topics covered in the review were the prevalence and nature of volatile substance abuse, successful prevention of such abuse and effective communication of information and messages about such abuse. The authors reported that the available evidence was limited. Their findings indicate that:

- Volatile substances should be included in drug education and given the same priority as other illicit substances. Research is necessary to determine the appropriate age at which to introduce volatile inhalant education and identify the message(s) that should be given. This is because research carried out in England found that providing education to children about the dangers of volatile inhalant use had in some cases encouraged experimentation with volatile substances.
- Parental involvement is paramount in deterring children and teenagers from drug experimentation and continued use. Again, this means that parents must be aware of the dangers of volatile substance use, and should class these substances in the same category as other illicit drugs (such as heroin, cocaine or ecstasy).
- Manufacturers of volatile inhalants and solvents must be responsible to ensure they do all that is possible to deter abuse of these substances. This includes putting warning messages on packaging about the dangers of inhalation of these substances and designing containers that deter inhalation of the product.
- Existing legislation on the selling of volatile inhalants or solvents to minors needs to be reviewed and enforced.
- Very often volatile inhalants and solvents are classed differently to other illicit substances and are therefore not given the same priority at a policy-making level. As a result, these substances are not always specifically addressed in strategies, education programs, control and treatment.

(Simone Walsh and Jean Long)

1. National Institute on Drug Abuse (2007) *InfoFacts: inhalants.* Washington DC: NIDA, Department of Health and Human Services. Accessed 11 November 2009 at www.nida.nih.gov/PDF/Infofacts/Inhalants07.pdf
2. National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2008). *Drug use in Ireland and Northern Ireland: first results from the 2006/2007 drug prevalence survey.* Bulletin 1. Dublin: NACD.
3. Houghton F, Cowley H, Meehan F and Kelleher K (2008) Drug and solvent misuse in national school children in mid-west Ireland. *Irish Journal of Psychological Medicine, 35(4): 157-158.*
4. Hibell B, Guttormsson U, Ahlström S, Balakireva O, Bjarnason T, Kokkevi A *et al.* (2009) *The 2007 ESPAD report: substance use among students in 35 European countries.* Stockholm: The Swedish Council for Information on Alcohol and Other Drugs (CAN) and the Pompidou Group of the Council of Europe.
5. Van Hout MC and O'Connor S (2008) Solvent use among young Irish adolescents: a growing concern for youth workers, teachers and parents? *Drugs and Alcohol Today,* 8(1): 27–37.
6. Lyons S, Lynn E, Walsh S and Long J (2008) *Trends in drug-related deaths and deaths among drug users in Ireland, 1998 to 2005.* HRB Trends Series 4. Dublin: Health Research Board.
7. Skellington Orr K and Shewan D (2006) *Substance misuse research: review of evidence relating to volatile substance abuse in Scotland.* Edinburgh: Scottish Executive. Accessed 11 November 2009 at www.scotland.gov.uk/Resource/Doc/147377/0038818.pdf

Coolmine launches three-year strategic plan

Minister Curran with Declan Arthur and Paul Conlon of the Coolmine Centre at the official launch, earlier this year, of the Mother and Child Facility at Ashleigh House

Coolmine Therapeutic Community (CTC) launched its strategic plan for 2009–2011 in September 2009.[1] The plan was officially launched by John Curran TD, Minister for State with responsibility for drugs strategy. Coolmine Chief Executive Paul Conlon spoke of the challenges facing services providing drug treatment and rehabilitation.

Recent developments in Coolmine reflect the community's continuing commitment to the provision of a continuum of care, and to a vision of recovery which emphasises an enhanced quality of life rather than mere abstinence from drugs. The chief executive's overview lists Coolmine's achievements of note under the 2006–2008 strategy:

- creation of formal client consultation and participation structures;
- initiation of a stabilisation day programme for active drug users in partnership with other service providers;
- establishment of clinical governance structures and procedures, including the creation of a limited detoxification service within its residential facilities;
- provision of full-time staff cover in residential facilities;
- reduction in the length of stay in all three residential facilities to an average of six months;
- change of institutional culture and styles at Ashleigh Hose to reflect the fact that the facility caters for mothers and children;
- provision of five community aftercare houses to facilitate clients who have completed primary treatment programmes;
- establishment of a part–time career guidance and counselling service and enhanced use of the Community Employment scheme to benefit clients;
- completed refurbishment of two of its main facilities and commencement of work on the third; and
- creation of an improved fundraising strategy.

The new strategy identifies and links its two key objectives:

To consolidate and develop existing quality services

- establish an advisory group to ensure clinical governance, ongoing training and best practice is achieved;
- increase resources and training to ensure that existing programmes are accessible to a greater range of people;
- develop a volunteer programme and foster stronger links with external service providers; and
- develop strategic partnerships with a number of housing providers to ensure that clients have the best opportunities for accommodation.

To build a strong and sustainable organisation

- complete capital works;
- improve internal communications structures, and implement an effective IT strategy;
- develop an external communications strategy to raise Coolmine's profile and to aid fundraising efforts; and
- explore potential development opportunities at Coolmine Lodge site for housing units or a residential detoxification unit.

(Vivion McGuire)

1. Coolmine Therapeutic Community (2009) *Supporting people in changing times: strategic plan 2009 to 2011.* Dublin: Coolmine Therapeutic Community. www.coolminetc.ie

Provision of social support for people with drug addictions

The Comptroller and Auditor General recently reported on his examination of publicly funded treatment and rehabilitation services for people with drug addictions.[1] Issue 31 of *Drugnet Ireland* presented the report's findings with respect to drug treatment.[2] This article presents the findings with respect to provision of support for people seeking, receiving or following treatment for addiction in the key areas of

- accommodation
- education, training and employment
- childcare

Accommodation

Drawing on data from the National Drug Treatment Reporting System (NDTRS), the report states that some 7% to 8% of those entering or re-entering treatment each year are recorded as homeless, and a further 3% to 4% are in some form of unstable accommodation. Being homeless or living in unstable accommodation can undermine the gains that would be expected from engaging in drug treatment.[3]

The report recommends that separate accommodation be provided for drug users in treatment and for those who have completed treatment and wish to pursue a drug-free lifestyle; this would support recovering drug users by reducing the risk of relapse. The report highlights the role of step-down facilities in supporting those who have completed treatment, and notes that the Health Service Executive (HSE) currently funds 29 step-down beds for people recovering from drug addiction. It also notes that demand for accommodation places for recovering drug users far exceeds the number of beds available.

An evaluation of one of the HSE step-down projects showed the positive outcomes that can be achieved by recovering drug users.[4] Of 12 former clients who completed that programme, six were living independently, two were living with a family member or a partner and four were living in further transitional housing. Self-reporting by these clients and their key workers suggested that they were no longer abusing drugs and were in education, training or employment.

The C and AG report highlights the importance of collecting data on the percentage of people using step-down facilities who progress to independent living. The report also calls for national monitoring of waiting times for access to transitional or long-term accommodation by those undergoing rehabilitation.

Education, training and employment

The report notes that, consistently, around 60% of those commencing treatment report that they are unemployed, 20% report being in paid employment and 4% report participating in FÁS or other training schemes. Since the introduction of the FÁS Special Community Employment (CE) scheme designed to provide vocational training for recovering drug users, there has been a consistent shortfall in the uptake of places, with a decline from 90% in 2004 to 83% in 2007. The reasons for this decline are not clear and, as the report points out, the decline 'occurred at a time when the numbers in drug treatment were increasing'.

The report notes that FÁS now draws up Individual Learner Plans for people registering with them and suggests that this approach could potentially fit well with the individual care plans that might be developed with key workers to help those in drug treatment access structured and suitable education and training interventions at the appropriate time. The report also suggests that the effectiveness of projects under the Special CE scheme should be evaluated.

Childcare

According to the report, 15% of those entering treatment for drug addiction in 2007 were living with dependent children. The report notes that the current provision of childcare services for drug misusers is limited, in that:

- the Health Service Executive does not provide childcare facilities on most addiction service premises;
- community and voluntary groups provide limited childcare facilities; and
- very few Special CE projects provide childcare for participants.

The report cites the following recommendations made by the Working Group on Drugs Rehabilitation:

- An audit of gaps in childcare provision for children of drug users should be undertaken.
- Childcare services for children of drug users should focus on the developmental needs of children.
- Parenting programmes for drug users should be developed and implemented.

The report concludes by proposing a means by which these issues can be acted on within the broader framework of treatment and rehabilitation:

- Protocols developed for interagency work should cover referral and reporting to social support providers, e.g. local authority housing department and FÁS.
- Waiting times for accessing social support services should be formally monitored and reported on.
- Comprehensive care planning would help to identify the extent to which those receiving treatment require assistance with accommodation.

(Martin Keane)

1. Comptroller and Auditor General and Department of Community, Rural and Gaeltacht Affairs (2009) *Drug addiction treatment and rehabilitation.* Special report, Value for Money 64. Dublin: Office of the Comptroller and Auditor General. www.audgen.gov.ie
2. Long J (2009) Comptroller and Auditor General report on drug treatment. *Drugnet Ireland*, (31): 13–14.
3. Keane M (2007) *Social reintegration as a response to drug use in Ireland.* HRB Overview Series 5. Dublin: Health Research Board.
4. Juniper Consulting (2008) *Step-Down programme George's Hill: evaluation report.* Dublin: Focus Ireland.

Blueprint drugs education: findings from an evaluation

The Blueprint drugs education programme is an evidence-based, multi-component programme that was piloted in 23 schools in England during the spring terms of 2004 and 2005. The programme provided drug education lessons to children in Year 7 (when they were aged 11) and Year 8, complemented by four additional components: parents, media, health policy and community. The programme aimed to equip pupils with the knowledge and experience necessary to make informed choices about drug use. This article summarises the main findings from the responses of pupils and parents to the programme and the results of a prevalence survey that measured changes in behaviour and attitudes of pupils towards substance use.[1]

The evaluation

Pupils in the 23 schools completed a prevalence survey, which measured their attitudes and behaviours in relation to drug use, and an impact survey, which measured their reaction to the Blueprint programme. Parents or carers completed a survey which examined their awareness and opinions of Blueprint. A smaller sample of pupils from six local schools who received drugs education through Personal, Social, Health and Economic (PSHE) education classes was surveyed using some of the same measures used to assess the Blueprint pupils. Findings from this smaller sample are presented to provide context to the work; these schools do not act as a comparison group to the Blueprint schools.

Pupils' and parents' responses to Blueprint

- The vast majority of Blueprint pupils reported that the lessons were an important source of information about drugs.
- Pupils enjoyed the format of the lessons, in particular the active teaching methods, such as role play.
- Pupils learnt some of the skills needed to deal with situations in which they might be offered drugs.
- Pupils demonstrated good recall of drug knowledge.
- Parents approved of their children being taught about drugs at school.
- The Blueprint materials format was effective in engaging some parents in drug education and the parents who took part felt that the material increased their knowledge and helped them talk to their children about drugs. Overall, it was difficult to engage parents with the programme.

Prevalence, attitudes, and drug-use norms

- Among Blueprint pupils, prevalence of smoking, drinking and drug use increased between Year 7 and Year 10.
- A higher level of drug taking was associated with previous use, truancy and exclusion.
- Many pupils overestimated the number of their peers who smoked and drank alcohol; fewer overestimated the number who used drugs.
- The perception by pupils of a high prevalence rate of drug use, smoking and alcohol use among their peers was associated with truancy, exclusion, being older and being a girl.
- Perceived acceptability of smoking, drinking alcohol and drug use increased between Year 7 and Year 10. Drinking alcohol was considered more acceptable than smoking or taking drugs.

Findings from local school data

- Pupils from local schools were positive about drug education they received as part of PSHE lessons.
- Almost half of pupils cited PSHE lessons on drug education as important sources of information, and the content and delivery of lessons were rated highly.
- Pupils demonstrated high recall of drug knowledge.
- Prevalence of smoking, drinking and drug use increased between Year 7 and Year 10.
- Parents approved of their children receiving drugs education at school.

According to the evaluation team, 'The original design of the Blueprint evaluation was not sufficiently robust to allow an evaluation of impact and outcomes, and consequently the evaluation did not draw any conclusions on the efficacy of Blueprint in comparison to existing drug education programmes.[2] ... Instead, it was decided that the implementation of the programme would be the main focus of the evaluation, and that the ratio of 23 Blueprint schools and six local schools would be kept so that large-scale implementation could be assessed.' While it was still planned to draw some comparisons between the two samples, 'academic and statistical reviews concluded that to present the data in this way would be misleading, given that the sample sizes are not sufficient to detect real differences between the groups'. Instead, findings from the six local schools were presented to provide context to the work; these schools did not act as a comparison group to the Blueprint schools.

(Martin Keane)

1. Blueprint Evaluation Team (2009) *Blueprint drugs education: the responses of pupils and parents to the programme.* London: Home Office. www.ism.stir.ac.uk/pdf_docs/Blueprint/finalreport.pdf
2. Two additional reports of the Blueprint evaluation, the delivery and practitioner reports, were released in November 2007 and are available at http://drugs.homeoffice.gov.uk/publication-search/blueprint/dpreports/

Adolescent substance use in south-east Ireland

Van Hout completed a comprehensive study of drug and alcohol use among adolescents in the south east of Ireland from the standpoint of young people, parents and service providers. This article presents a summary of the findings in relation to each of the three groups, as published in separate journal articles.

Substance use reported by adolescents

The author completed semi-structured interviews with a random sample of 220 children aged 15–17 years from schools and youth training centres in the area.[1] Just under one-quarter of the respondents reported ever using an illicit drug, and the majority who had tried drugs were boys. Almost all said that they had been offered drugs and that drugs were easily available in urban areas. The majority believed that drug use would increase in the future in the area. They said that neither the police nor the schools took action to stop dealing or drug use in public. Drugs were purchased over the phone and could even be delivered to the schoolyard.

Cannabis was the most common drug used and, excluding alcohol and volatile inhalants, was the first drug used by the majority. A small number reported that ecstasy or amphetamine was their first drug. Alcohol was usually consumed alongside illicit drugs. Cannabis was perceived as a safe drug, and cocaine, heroin and speed as dangerous drugs. Most took drugs because they were curious or bored, or their friends were taking them. Some said that drugs helped them to relax or gave them a buzz. The majority were aged between 10 and 15 years when they took their first drug, which was usually given by a friend or older sibling; the initial occasion was unplanned; and almost half felt ill after taking the drug. A small number reported that they clubbed together with friends to buy drugs.

Some respondents reported that they controlled their drug use to prevent addiction, overdose, or other physical symptoms. Very few were worried about the legal consequences of illicit drug use. Some of the older respondents reported that they had ceased illicit drug use because drugs had lost their appeal, or they had experienced negative effects, or they preferred alcohol. The respondents who had never taken drugs gave the following reasons for their decision: drugs are dangerous, they have side effects, and/or drug use could be difficult to control. Some respondents were afraid of their parents' reaction if they were discovered using drugs.

Parents' views

To ascertain parents' views on youth substance use, the author conducted semi-structured interviews with a convenience sample of parents (34 mothers and 21 fathers) of adolescent children attending three rural schools.[2] The interviews included questions relating to the parents' perceptions of youth drug and alcohol use (in terms of both recreational and problematic use in their communities), drug availability, perceptions of risk, types of settings for adolescent substance use, service provision and drug information. The parents were not questioned about their own children but about youth in general.

The results suggest that the parents were concerned about the increased exposure to drugs among youth in local rural communities. The majority of parents were aware of youth alcohol use, they were concerned about all drugs, they were not aware of specific differences in drug-related risk, and they had difficulty comprehending harm-reduction principles. Most parents recognised the need for greater parental monitoring of their children's free time and improved parent–child discourse, as well as the need for more widespread drug education, and the provision of visible and accessible services and support for the families of problem substance users.

The author concluded that life in contemporary rural Ireland is influenced by dominant social changes in terms of the normalisation of alcohol and drug use in youth subcultures. This is facilitated by increasing fragmentation of traditional rural family norms and values, emerging acceptability of alcohol and drug use in recreation time and the increasing availability of alcohol and drugs.

Service providers' views

The author also explored the perspectives of 78 service providers in the area on youth substance use and current service provision.[3] The service providers worked in youth, community, addiction, education or health services.

As did the parents and the adolescents, the service providers believed that illicit drugs and drug use had become a normal aspect of society in the area. They said that use had increased because the availability of drugs had increased, young people had more disposable income and greater freedom, and their free time was not monitored by parents. They believed that young people had a positive attitude to alcohol use and a facilitating attitude to drug use, and that this encouraged experimentation. In addition, children had more knowledge about the effects of individual drugs and the effects of mixing them. Drug use included use of solvents and inappropriate use of prescription medication. The service providers said that teachers were trying to control drug dealing and use in the schoolyard, whereas the young people felt that there was not enough control in the yard.

Adolescent substance use in south-east Ireland *(continued)*

The service providers reported that children are introduced to alcohol at a young age and observe their parents and siblings drinking to excess. They cited poor parental monitoring and unstructured leisure time as contributing factors. Young people were observed purchasing and sharing drugs among close peers or best friends. Drug and alcohol use occurred in fields, on the streets or at friends' houses. Children as young as 10 years were known to use drugs, and boys were more likely than girls to experiment. Young people had developed an informal hierarchy of drugs, according to their perceived level of harm, with heroin at the top of the scale and cannabis at the bottom. Young people thought that heroin was safe if smoked and that cannabis was as safe as cigarettes.

According to the service providers, most children experiment with drug use and mature out of it, but children experiencing family problems and disruption are more likely to develop problem drug or alcohol use. The providers also pointed out that adolescent diagnostics and services in the south east of Ireland are based on adult models.

(Jean Long)

1. Van Hout MC (2009) Drug and alcohol use among rural Irish adolescents: a brief exploratory study. *Drugs and Alcohol Today*, 9(1): 20–26.
2. Van Hout MC (2009) Youth alcohol and drug use in rural Ireland: parents' views. *Rural and Remote Health*, 9: 1171.
3. Van Hout MC (2009) An illustrative picture of Irish youth substance use. *Journal of Alcohol & Drug Education,* 53(1): 7–14.

Substance misuse in the HSE South Eastern Area

The Health Service Executive (HSE) South published the report *Data co-ordination overview of drug misuse 2008* in August 2009.[1] The report comprises sections relating to treatment services, substance-related offences and cases dealt with by the Probation Service in the HSE South Eastern Area.

The section on treatment services analyses data collected from statutory and voluntary drug and alcohol treatment agencies, acute general hospitals and psychiatric hospitals in the HSE South Eastern Area. Data from the drug and alcohol treatment services are returned to the National Drug Treatment Reporting System in the Health Research Board.

The total number of individuals seeking treatment in 2008 was 2,686, a decrease of 265 on the 2007 figure. Some 60 concerned persons (family members or close friends of substance users) contacted treatment services in the south east in 2008.

The combined total of continuous care clients and new referrals who were treated was 2,376. Of these:

- 68% were male and 32% were female.
- 13% were under the age of 20, and 41% were aged between 20 and 34.
- Alcohol (62%) was the most common main problem substance for which treatment was sought, followed by heroin (12%), cannabis (11%), and cocaine (5%). Cannabis, which had been second in this ranking for a number of years, was overtaken by heroin in 2008.
- The numbers seeking treatment for alcohol and cannabis have decreased annually from 2007 onwards. Up to 2007, cocaine figures were rising, but the numbers seeking treatment for cocaine decreased in 2008. The numbers seeking treatment for heroin, MDMA, amphetamines and volatile inhalants increased.

A total of 1,972 clients exited the services in 2008. Less than half (44%) of these clients completed treatment; 27% refused further sessions or did not return for subsequent appointments; 13% did not wish to attend further sessions as they considered themselves to be stable; 11% were transferred to another site for further treatment; 4% exited because of non-compliance, 1% exited for other reasons, and 0.6% died.

The client's condition on discharge was classified by service providers as stable if they had responded to treatment, and unstable if they had not responded. Of the 1,972 cases analysed, 1,347 (68%) were stable on exit from the services, 597 (30%) were unstable, the condition of 17 (0.9%) was classified as 'not known' and 11 (0.6%) had died.

Data presented in this report are useful for planning future services.

(Anne Marie Carew)

1. Kidd M (2009) *Data co-ordination overview of drug misuse 2009.* Waterford: HSE South.

Mental health and young people: a review of CBT-based interventions

The recently published results of a systematic review shed some light on what works in reducing or preventing mental health problems among young people.[1] One of the questions addressed in the review was:

> Are secondary school-based mental health interventions based on cognitive behavioural techniques effective in preventing or alleviating depression, anxiety and suicidality among young people?

Following an extensive search of a number of relevant databases, repeated screening of thousands of studies and an assessment of the quality of potential studies for synthesis, 17 randomised controlled trials (RCTs) were included in the final synthesis. All the interventions were based on techniques derived from cognitive behavioural therapy (CBT), and were delivered to either small groups or entire classes. The authors point out that the CBT approach is primarily based on Beck's cognitive model of depression, which focuses primarily on the relationships between cognitions, feeling and behaviours.[2]

All the studies included in the review evaluated CBT interventions for effectiveness in reducing or preventing the onset of the symptoms of a range of emotional disorders. None presented data on the impact of CBT interventions on suicidal thoughts or behaviours, and none stated that suicide prevention had been an explicit aim of the intervention. The interventions taught students a variety of techniques for problem solving and coping, including assertiveness training, relaxation, negotiation, positive thinking and communication. Interventions aimed at reducing anxiety focused on social skills training.

Findings on effectiveness of CBT interventions

Impact of CBT on depression outcomes
CBT interventions were effective in reducing depressive symptoms up to three months after the intervention had finished. The effect remained positive, although insignificant, at six- and twelve-month follow-up. Universal interventions were shown to improve depressive symptoms up to four weeks after delivery. Indicated interventions were shown to improve depressive symptoms up to six months after delivery. No evidence of harm was detected in any of the analysis. Interventions delivered by a member of school staff were found to be effective, while those delivered by external providers were not. Interventions of 10 or more sessions were effective up to three months post intervention. Shorter interventions, up to nine sessions, were found to be ineffective.

Impact of CBT on anxiety outcomes
CBT interventions were found to be effective in reducing anxiety immediately post intervention, and at six-month follow-up. There was insufficient data to evaluate the effectiveness of interventions delivered by internal school staff. Interventions delivered by external providers were not shown to be effective in reducing anxiety. Interventions of up to nine sessions were effective at six-month follow-up. Interventions of 10 sessions or more were found to be effective immediately post-intervention.

Recommendations for practice

The authors make a number of recommendations that may be useful to those wishing to implement preventive mental health programmes in secondary schools. Providers should consider the use of CBT-based interventions for reducing depression and anxiety levels. Given the uncertainties about the long-term benefits of universal interventions, efforts to prevent depression in young people might best be directed towards indicated interventions. Providers of preventive mental health services to young people should:

- consider using adequately trained and supported school staff to provide CBT-based interventions to young people;
- consider providing programmes of 10 or more weeks' duration; and
- be aware of, and consider monitoring, potential adverse effects (i.e. stigma associated with mental health problems).

Providers of preventive mental health services to young people who are considering providing universal, rather than indicated, interventions should evaluate the impact of the intervention on high- and low-risk groups. Providers implementing indicated interventions may wish to monitor any potential adverse effects due to stigma associated with mental health problems. While no studies of indicated prevention reported adverse outcomes, such as bullying, The authors warn of 'the potential risk that participants identified as receiving such interventions may suffer adversely due to the social stigma attached to suffering from an emotional or mental health problem'.

(Martin Keane)

1. Kavanagh J, Oliver S, Caird J, Tucker H, Greaves A, Harden A *et al.* (2009) *Inequalities and the mental health of young people: a systematic review of secondary school-based cognitive behavioural interventions.* London: University of London, EPPI-Centre.
2. Beck AT (1974) The development of depression: a cognitive model. In: Friedman R and Katz M (eds) *Psychology of depression: contemporary theory and research.* Washington, DC: Winston-Wiley. pp. 3–27.

Mental health issues and alcohol abuse among college students

A recent study determined the prevalence and correlates of depression, alcohol abuse and suicidal ideation among students in two universities – Trinity College Dublin and University College Dublin.[1] While university students around the world are vulnerable to depression, alcohol abuse and suicidality, there are three reasons for hypothesising that Irish students are at unusually high risk. First, the prevalence of depressive disorder in urban Ireland is high; second, Ireland has the third highest per capita consumption of alcohol in the EU and the highest rate of binge drinking; and third, the suicide rate among young Irish adults has increased and a large proportion of this age group is in full-time education.

Questionnaires were emailed to 539 pre-final year medical and business students, of whom 338 (63%) responded. The Beck Depression Inventory (BDI) was used to measure depression and suicidality, and the CAGE screening questionnaire[2] to assess alcohol abuse in the past month. Depression in the previous month was reported by 14% of students and was associated with lower social support and a greater number of stressful life events. Four per cent reported suicidal thoughts without intent, and 2% reported serious suicidal ideation. All suicidal ideation correlated positively with stressful life events and negatively with social support. A quarter of students scored 2 or more on the CAGE test, indicating an alcohol use disorder, with business students more likely than medical students to score at this level. Serious suicidal ideation correlated positively with CAGE total.

The variable most strongly correlated with depression, alcohol abuse and suicidal ideation was social support; social support appeared to be protective; for instance, as social support increased, depression decreased. However, the cross-sectional design of this study leaves the question of causality unanswered; it is possible that depressed participants underestimated their true level of social support. The authors conclude that students would benefit from an expansion of mental health and alcohol education, and of psychosocial services in universities. Further research could use more robust methods of diagnosis and more detailed evaluation of the demographic and psychosocial factors that predict serious mental illness.

(Deirdre Mongan)

1. Curran T, Gawley E, Casey P, Gill M and Crumlish N (2009) Depression, suicidality and alcohol abuse among medical and business students. *Irish Medical Journal,* 102(8): 249–251.

2. CAGE is an acronym formed from the initial letters of the four key words/phrases in the screening questionnaire – Cut down, Annoyed, Guilty, Eye-opener.

Physical activity as part of adolescent addiction treatment

Van Hout assessed the perception of social context and activity scales of adolescent substance abusers following participation in a physical activity intervention during residential drug treatment.[1] The increase in perception of social context value was measured by increased social interaction, group identification, trust, co-operation and social growth. The increase in perception of activity value was measured by increased enjoyment, self-efficacy, skill acquisition and confidence. The sample (n=47) was assessed on entry to treatment, on completion of treatment, at six weeks after treatment and at six months after treatment, using mean, standard deviation, and t-tests.

Participants were aged between 12 and 20 years, and 63% were male. In general, the overall mean scores for perception of social context value increased between entry to and completion of the treatment program decreased marginally six weeks after treatment, and returned to baseline levels after six months in aftercare. A small significant positive difference was recorded between entry and six weeks after treatment $p = 0.04$).

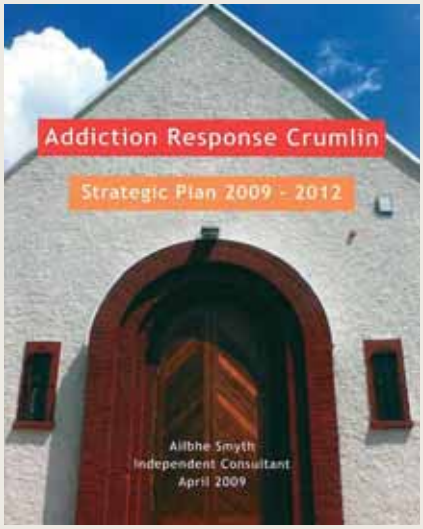
Perception of activity value increased between entry to and completion of the treatment program, increased again at six weeks after treatment, and decreased to below the baseline level six months following discharge. Positive significant differences were recorded between entry and six weeks after treatment ($p = 0.02$). This research illustrates the positive potential of physical activity as part of an adolescent residential treatment programme, and in the first six weeks following discharge. It notes that it was difficult to sustain the long-term benefits, and suggests that this aspect of the intervention needs to be explored.

(Jean Long)

1. Van Hout MC (2008) Perception of social context and activity following participation in a physical fitness intervention during residential adolescent addiction treatment. *American Journal of Recreation Therapy*, 7(4): 27–45.

ARC strategic plan 2009–2012

L to r: Dr Ailbhe Smyth, Cllr Ruairi McGinley, Lord Mayor Cllr Emer Costello, Cllr Eric Byrne, Ms Aoife Fitzgerald Co-ordinator D12 LDTF, Ms Susan Collins and Mr Jimmy Norman of ARC



Addiction Response Crumlin (ARC) published its strategic plan for 2009–2012 on 31 July 2009.[1] Commissioned by the ARC board of management in the autumn of 2008 during times of economic uncertainty, the plan was launched by the Lord Mayor of Dublin Emer Costello. ARC co-ordinator Susan Collins spoke of the uncertain times ahead for all service providers and the challenges that may arise.

Four strategic priorities are identified for the three-year period of the plan, which will allow ARC to measure its achievements effectively:

- building organisational capacity;
- sustaining and strengthen-ing quality service;
- fostering effective external relationships; and
- ensuring quality governance and accountability.

Ms Collins, in consultation with the board of management and staff, will set up a high-level steering group to oversee the implementation of the strategy and monitor it into the future. At the end of the three-year period this group will evaluate and communicate the strategy achievements.

To respond effectively to the needs of problem drug users, their families and the local community in Dublin 12, ARC will need to:

- keep existing baseline services in place;
- retain current staff team;
- maintain high standards and quality of treatment and care;
- ensure that innovative and flexible approaches within services are supported; and
- maintain and strengthen relationships with community and state bodies.

For further information on ARC services, please visit the website at www.addictionresponsecrumlin.ie

(Vivion McGuire)

1. Addiction Response Crumlin (2009) *Strategic plan 2009–2012.* Dublin: ARC.

MQI annual review 2008

The Merchants Quay Ireland (MQI) annual review for 2008 was launched on 29 September 2009 by Mr Ryan Tubridy.[1]

MQI's needle-exchange service recorded that the number of client visits in 2008 remained steady at just under 40,000; however, almost 1,000 of those visits were by new clients. The report also highlights a continuing high level of demand for homeless services, with a 4% increase in the number of meals provided for homeless people. There was a decrease in the numbers seeking help from MQI's primary health care services, resulting from a decision to limit the number of attendees and give adequate time to those presenting.

In 2008 MQI completed the implementation of a national prison-based addiction counselling service to 13 prisons and is providing in excess of 1,000 counselling hours per month and working with 440 prisoners. With the support of the Vodafone Ireland Foundation, MQI has expanded its family support service, which now includes a confidential helpline, counselling, support groups and drug education awareness for families. In late 2008 MQI in association with the Midland Regional Drugs Task Force introduced the Midlands Family Support and Community Harm Reduction Service, providing outreach and working with families of those actively using drugs.

The types of service offered by MQI and the numbers of people accessing them in 2008 are shown below.

(Vivion McGuire)

1. Merchants Quay Ireland (2009) *Annual review 2008*. Dublin: MQI.

Service	Type of intervention	No. of participants	Outcomes
Needle-exchange and health-promotion services	Promoting safer injecting techniques	Not available	Not available
	HIV and hepatitis prevention	(1,000 new clients)	
	Safe sex advice	904	
	Information on overdose	Not available	
Stabilisation services	Methadone substitution	20	Not available
	Supportive day programmes	Not available	Not available
	Gateway programme	Not available	Not available
	Counselling	382	Not available
Settlement service	Assist service users to access interim and long-term accommodation	34 (monthly average)	Not available
Integration programmes	Access to transitional accommodation Ballymount House and Athlone for up to 24 weeks	15	11 clients moved to longer-term accommodation
	Group and one-to-one therapeutic sessions		
Training and work programmes	FÁS Community Employment scheme	124	32% secured permanent employment or moved to further education
High Park	17-week, drug-free residential programme including individual counselling, group therapy, educational groups, work assignments and recreational activities	59 (of whom 18 were admitted for detoxification)	14 completed detox
St Francis Farm	Therapeutic facility offering a 6–12-month programme	29	14 completed three months or more

Drugs in focus – policy briefing

Extract from Issue No. 20: Responding to drug driving in Europe

Many of the accidents and deaths that occur on European roads are caused by drivers whose performance is impaired by a psychoactive substance. Alcohol alone is estimated to account for up to 10 000 road deaths a year in the European Union, one quarter of all road deaths. No comparable figures are available for road accidents related to illicit drugs and psychoactive medicines, though these have been receiving increasing attention over the past decade.

The complex issue of drug driving is currently being investigated by DRUID, a major EU project that began in 2006 and will continue until 2010. DRUID aims to provide a solid basis for harmonised, EU-wide regulations for driving under the influence of alcohol, drugs and medicine. Until then, this policy briefing summarises the key issues facing policymakers and describes developments across Europe that may assist decision-making on the topic.

Key issues at a glance

1. Reports of drug driving incidents often receive much media attention. But, few countries have reliable statistics on the prevalence of driving under the influence of drugs.
2. Obtaining sound scientific evidence on behavioural effects, prevalence and accident risk is difficult with the available data. Many of the studies have small samples and it is often difficult to generalise from their results.
3. Reflecting the scientific debate about the precise effects of the substances, the legal definition of the offence of driving under the influence of drugs differs among EU Member States.
4. Various psychoactive medicines, which might or might not be legally prescribed and consumed, can impair driving skills.
5. Currently, police experience considerable difficulty with the accurate and rapid identification of drug driving at the roadside.
6. The effectiveness of information campaigns to prevent drug driving is open to question. Key audiences may not be hearing the message, or they may be ignoring it.

Conclusions and policy considerations

1. Surveys on the prevalence of drugs in drivers need to be conducted in all EU Member States. Testing all drivers involved in a fatal accident for drug and alcohol use would provide an important source of information for monitoring the problem.
2. New guidelines on study design are available that take into account the variety of legal and practical constraints in different countries. They aim to improve comparability among studies and may facilitate exchange of best practice.
3. Policymakers should consider the latest scientific information available when designing legal responses. The level at which a driver will be deemed in breach of the law should be clear for all stakeholders and the public.
4. National laws and their enforcement need to strike a balance between concerns about ensuring road safety and the therapeutic needs of individuals.
5. Legal frameworks require review, as even with the limitations of existing testing methodology, more effective procedures are possible. And, new options are likely to become available.
6. Prevention campaigns should target specific risk groups and substances; be based on scientific evidence; and rigorously evaluated for impact on behaviour and attitudes.

Drugnet Europe is the quarterly newsletter of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). *Drugs in focus* is a series of policy briefings published by the EMCDDA. Both publications are available at www.emcdda.europa.eu.

If you would like a hard copy of the current or future issues of either publication, please contact:

Alcohol and Drug Research Unit, Health Research Board, Knockmaun House, 42–47 Lower Mount Street, Dublin 2. Tel: 01 2345 127; Email: adru@hrb.ie.

From *Drugnet Europe*

Keeping pace with a shifting drug phenomenon

Cited from Drugnet Europe, *No. 68, October–December 2009*

'Effective and evidence-based policies are increasingly necessary as challenges in the drugs field grow ever more complex', said EMCDDA Director Wolfgang Götz, in his message launching the *Annual report 2009*: t*he state of the drugs problem in Europe.* A common theme running through this year's report is the need for our vision to keep pace with an ever-shifting drug phenomenon and that well-conceived interventions can deliver real benefits and value.

Highlighted in particular is Europe's increasingly volatile synthetic drug market, where 'highly innovative' suppliers circumvent drug controls by offering alternatives to controlled drugs. While this practice is not new, what is new is the wide range of substances now on offer, the growing use of the Internet and the aggressive and sophisticated marketing of products. The difficulties of 'hitting a moving target' are described in the report.

As regards the more traditionally used drugs, 'overall, we are not seeing major increases and, in some areas, trends appear to be downwards', said Götz. Indicators for amphetamine and ecstasy use, for example, still suggest an overall steady or declining situation. And, new data confirm a continued fall in cannabis use, particularly among young people. However, he added: 'cocaine and heroin continue to maintain a firm hold on Europe's drug scene'. And polydrug use is now widespread in Europe, increasing risks and complicating the delivery of treatment.

In brief

On 26 June 2009 the **International Society for the Study of Drug Policy (ISSDP)** published a selection of papers from its second annual conference, held in Lisbon in March 2008, in the **International Journal of Drug Policy** (Volume 20/6). The guest editors (Henri Bergeron and Peter Reuter) suggest that after a period of relative stability in the 1990s, drug policy now appears to be in a state of flux, particularly in Europe. Whereas the ultimate goal of previous legislation and policy was to save users from themselves, there seems to be a shift towards policies that seek to protect communities, society and public order.

Increased controls on rave parties, legislation against drugs and driving, and the development of drug testing are examples; the authors note that such initiatives have been particularly prominent in Ireland, the Netherlands, Great Britain and Belgium. They note the same tendency in policies regarding alcohol consumption. While they observe that treatment and harm reduction policies still seek to minimise the adverse consequences of use for drug users and to care for drug users, greater attention is being given to public health concerns, as evidenced by the growing adoption of epidemiological and risk reasoning to analyse drug issues – a reasoning that reframes drug use in terms of epidemics that should be controlled as a threat to the public health of communities and society.

The authors associate this increasing focus on negative consequences for communities and society, rather than on harm to the individual, with growing activism by civil society groups. Individuals tend now to group and call on the state to handle the collective negative consequences of drug use, such as the gathering of drug users in their neighbourhood, syringes in the streets and playgrounds, and dealing in the street. The authors suggest that a new actor – the 'victim', the one experiencing drug-use-related troubles, as opposed to the user – may be appearing in the drug policy arena and influencing policy decisions. www.ihra.net/www.issdp.org

In June 2009 **Crosscare's Drug & Alcohol Programme (DAP)** launched a website listing counsellors' contact details. The purpose is to provide a national online database of fully-qualified and accredited counsellors/psychotherapists and professional counselling centres operating in Ireland. www.counsellingdirectory.ie

On 10 July 2009 the **Alcohol Marketing Communications Monitoring Body (AMCMB)** published its third annual report. It concludes that there had been overall compliance in 2008 with the Voluntary Codes to limit the exposure of young people to alcohol advertising. www.dohc.ie

On 2 September 2009 the **National Office for Suicide Prevention** published its 2008 annual report. Among other matters, it reports on prevention activities that focus on substance awareness. www.dohc.ie

On 10 September 2009 the **Mental Health Commission (MHC)** published the ***Report of the Joint Working Group on mental health services and the police 2009.*** The authors state that a considerable proportion of social crises in the community are of a psychiatric nature, involving both adults and children, and are often connected not just with mental illness but with a range of other social factors, including alcohol and drug abuse. They recommend the urgent implementation of national policy in relation to the document Vision for Change and the Primary Care Strategy; the creation of a 24-hour, 7-day a week statutory social work service; expanding training for the Garda Síochána on community and social services; joint protocols between the mental health services and the Garda Síochána, and involving users and carers in the drawing up of these protocols; a feasibility study on jointly-staffed crisis intervention teams, made up of mental health personnel and members of the Garda Síochána; and court diversion programmes for dealing with minor criminal matters involving individuals with mental health problems. www.mhcirl.ie

On 24 and 25 September 2009 the **European Society for Social Drug Research (ESSD)** held its 20th conference in Belfast. Conference themes included drug policy, trends and patterns in drug use, drug markets, drug-using lifestyles, theories and concepts, and methodological perspectives in drug research. www.essd-research.eu.

On 10 October 2009 the renewed **Programme for Government** was released. Alcohol and drugs are mentioned three times under the heading A More Caring and Just Society: 'We will introduce stricter requirements for labelling of alcohol products … We will implement the new Drugs Strategy… We will continue to target Garda actions within communities experiencing significant anti-social behaviour and drug crime.' www.taoiseach.ie

On 15 October 2009 a **Community Cashback Fund** of £4 million was launched as a pilot scheme by the UK's Home Office. Using cash and assets seized from criminals, the fund gives local people a direct say in how criminal assets are spent. More than 45,000 votes were received from members of the public for 1,225 community projects via a dedicated website, and through neighbourhood policing meetings and citizens' panels; 269 projects have been allocated funding for 2009/10. www.cashback.cjsonline.gov.uk/

On 28 October 2009 **Issues to Consider before Reforming California State Law regarding Marijuana** were presented by Rosalie Liccardo Pacula, Co-Director of the RAND Drug Policy Research Center (DPRC), before the California State Assembly Public Safety Committee. An economist, Pacula argues that California has insufficient information to decide on the matter and that it should conduct a full cost-benefit analysis. She explores the challenges and identified the important factors to consider in constructing a realistic cost-benefit calculation of the legalisation of marijuana. www.rand.org/multi/dprc

In October 2009 the **Joseph Rowntree Foundation** published **Communities in recession: the reality in four neighbourhoods.** It describes the circumstances of disadvantaged people and communities in four areas in England and Wales during the recession, as observed in July 2009. Author Karen Day concludes, '… the current debate over the official end of the recession is premature. All the political parties have acknowledged the inevitable future reduction in public services, fuelled by higher public borrowing and a decrease in tax receipts. But what hasn't been recognised is the potential impact these cuts may have, triggering a second recession unique to deprived communities. Many of these places are dependent on public services – from free school buses to drug outreach services, even police community support officers – to cushion their community infrastructure. In the rush to proclaim the end of the economic downturn, these places could be overlooked just as these cuts start to bite, pulling them further into poverty and widening the gap in inequalities even more.' www.jrf.org.uk

(Compiled by Brigid Pike)

Recent publications

Journal articles

Management of neonatal abstinence syndrome: a national survey and review of practice

O'Grady MJ, Hopewell J and White MJ

Archives of Disease in Childhood. Fetal and Neonatal Edition 2009; 94(4): F249–52
www.drugsandalcohol.ie/12395/

Aim: To ascertain the present management of neonatal abstinence syndrome (NAS) in neonatal units in the UK and Ireland.

Methods: Postal questionnaire to 235 neonatal units, with telephone follow-up of non-respondents.

Results: The response rate was 90% (211/235), and 96% (190/211) of respondents had a formal NAS guideline. The median number of infants treated annually for NAS was six (range 1–100). The method of Finnegan was the most widely used scoring system (52%) for the UK and Ireland combined and 93% for Ireland. Morphine sulphate was the most commonly used first line agent for both opiate (92%) and polysubstance (69%) withdrawal. Phenobarbitone was used as a first line therapy in 62% of units based in Ireland. Dosing regimens varied widely. Units using a maximum daily morphine dose of <400 microg/kg/day were more likely to require the addition of a second agent (76% vs 58%, p = 0.027). Phenobarbitone was the drug of choice to treat seizures secondary to both opiate and polydrug withdrawal in 73% and 81% of units, respectively. Fifty-seven (29%) units allowed infants to be discharged home on medication; of these, 58% allowed administration of opiates in the community and in almost half of cases this was managed by a parent. Mothers on methadone whose serology was positive for hepatitis B and/or hepatitis C were four times more likely to be discouraged from breastfeeding. Over half (55%) of the units had a liaison midwife.

Conclusions: The majority of units currently use an opiate as the drug of first choice as recommended. Doses utilised and second agents added vary significantly between units. Many of our findings reflect the lack of high-quality randomised studies regarding management of NAS.

Alcohol and drug screening of occupational drivers for preventing injury

Cashman CM, Ruotsalainen JH, Greiner BA, Beirne PV and Verbeek JH

Cochrane Database of Systematic Reviews 2009, Issue 2. Art. No.: CD006566. DOI: 10.1002/14651858.CD006566.pub2. www.drugsandalcohol.ie/11870/

The objective of this review was to assess the effectiveness of alcohol and drug screening of occupational drivers who operate motorised vehicles in preventing injury or work-related effects such as sickness absence related to injury.

Studies included in this review were selected from among the following: randomised controlled trials (RCTs), cluster-randomised trials, controlled clinical trials, controlled before and after studies (more than three time points to be measured before and after the study) and interrupted time-series (ITS) studies that evaluated alcohol or drug screening interventions for occupational drivers (compared to another intervention or no intervention) with an outcome measured as a reduction in injury or a proxy measure thereof.

Two review authors independently extracted data and assessed study quality. Authors of the included studies were contacted for further information.

The review authors included two interrupted time-series studies conducted in the USA. One study was conducted in five large US transportation companies (N = 115,019) that carried passengers and/or cargo. Monthly injury rates were available from 1983 to 1999. In the study company, two interventions of interest were evaluated: mandatory random drug testing and mandatory random and for-cause alcohol testing programmes. The third study focused only on mandatory random drug testing and was conducted on federal injury data that covered all truck drivers of interstate carriers.

Results were recalculated from raw data provided by the study authors. Following re-analysis, it was found that in one study mandatory random and for-cause alcohol testing was associated with a significant decrease in the level of injuries immediately following the intervention (-1.25 injuries/100 person years, 95% CI -2.29 to -0.21) but did not significantly affect the existing long-term downward trend (-0.28 injuries/100 person years/year, 95% CI -0.78 to 0.21).

Mandatory random drug testing was significantly associated with an immediate change in injury level following the intervention (1.26 injuries/100 person years, 95% CI 0.36 to 2.16) in one study, and in the second study there was no significant effect (-1.36/injuries/100 person years, 95% CI -1.69 to 0.41). In the long term, random drug testing was associated with a significant increase in the downward trend (-0.19 injuries/100 person years/year, 95% CI -0.30 to -0.07) in one study, the other study was also associated with a significant improvement in the long-term downward trend (-0.83 fatal accidents/100 million vehicle miles/year, 95% CI -1.08 to -0.58).

The authors conclude that there is insufficient evidence to advise for or against the use of drug and alcohol testing of occupational drivers for preventing injuries as a sole, effective, long-term solution in the context of workplace culture, peer interaction and other local factors. Cluster-randomised trials are needed to better address the effects of interventions for injury prevention in this occupational setting.

An illustrative picture of Irish youth substance use

Van Hout, MC

Journal of Alcohol & Drug Education 2009; 53 (1): 7–14
[Letter to the Editor] www.drugsandalcohol.ie/12266/

This letter describes recent exploratory research in Ireland undertaken to provide a snapshot of the perspectives of youth, community, addiction, educational and health service providers on youth substance use and current service provision. Interviews were undertaken with a self-selecting sample (based on availability, n=78) of these service providers in the South Eastern region of Ireland, which covers 13.5% of the State area and represents 20% of the national population. All interviews were analysed according to the themes that most consistently arose and that were pertinent to the research aims. The research yielded a picture of Irish youth substance use in terms of substances used, the potency of the peer and family setting for use and gaps and deficits in targeted service response.

Most interviewees felt that youth drug and alcohol use was increasing and of greater concern due to higher levels of

Recent publications *(continued)*

experimentation across all age groups and genders, with increased potential for the development of problematic use. Drug use was reported to present at ages 10 to 12 years, with alcohol as the most common precursor to drug initiation. Some remarked that boys were likely to experiment at earlier life stages than girls; but other service providers commented that girls were now presenting with increased levels of experimentation.

In general, it was reported that young people do not perceive their substance use to be of any risk to them, and that often the risk adds to the thrill of drug taking. It appears that negative first-time experiences do not deter them from using again, and that drug decisions are stimulated and encouraged by the strength of the relationship with the peer group in learning new drug-taking behaviours, attaching meaning to the drug experiences, and providing the context for drug use. For patterns of use, it was observed by those working closely with young substance users that internal sanctions for use were present and served to control levels of drug taking and combining, certain ways to behave and levels of drug use. It appears that young substance users do not want to appear either addicted or out of control, and that youth substance use is increasingly a social activity and not a criminal one. In addition, there is a reported 'hierarchy' of drugs in causing potential harm and social accommodation within youth culture, with heroin at the top of the scale and cannabis/hash at the lower end. Of some concern was the perception by some young people that heroin was safe if smoked and not administered intravenously. Most young people considered cannabis to be as safe as smoking cigarettes and were not concerned with any future health impact.

The research provides a key insight into the opinions, thoughts and knowledge relating to youth substance use from the viewpoints of a range of service providers. One must note that this information is based on 'perceptions' and is therefore anecdotal evidence. However, the information garnered in this study is useful in presenting the regional situation and guiding resources for timely drug and alcohol prevention strategies and community initiatives. In light of the findings, it is recommended that a multi-disciplinary approach involving individuals, health services, parents, schools, and local communities offer the most success in dealing with youth substance use trends.

Learning and memory deficits in ecstasy users and their neural correlates during a face-learning task

Roberts GM, Nestor L and Garavan H
Brain Research 2009; 1292: 71–81

Research has consistently shown that ecstasy users display impairments in learning and memory performance. In addition, working memory processing in ecstasy users has been shown to be associated with neural alterations in hippocampal and/or cortical regions as measured by functional magnetic resonance imaging (fMRI).

Using functional imaging and a face-learning task, we investigated neural correlates of encoding and recalling face-name associations in 20 recreational drug users whose predominant drug use was ecstasy, and in 20 controls. To address the potential confounding effects of cannabis use by the ecstasy-using group, a second analysis included 14 previously tested cannabis users (Nestor L *et al.* 2008; *Neuroimage* 40, 1328–1339).

Ecstasy users performed significantly worse in learning and memory compared to controls and cannabis users. A conjunction analysis of the encode and recall phases of the task revealed ecstasy-specific hyperactivity in bilateral frontal regions, left temporal, right parietal, bilateral temporal, and bilateral occipital brain regions. Ecstasy-specific hypoactivity was evident in the right dorsal anterior cingulated cortex (ACC) and left posterior cingulated cortex.

In both ecstasy and cannabis groups, brain activation was decreased in the right medial frontal gyrus, left parahippocampal gyrus, left dorsal cingulate gyrus, and left caudate. These results elucidated ecstasy-related deficits, only some of which might be attributed to cannabis use. These ecstasy-specific effects may be related to the vulnerability of isocortical and allocortical regions to the neurotoxic effects of ecstasy.

Alcohol use and the Traveller community in the west of Ireland

Van Hout MC
Drug and Alcohol Review 2010; 29(1): 59–63
www.drugsandalcohol.ie/12256/

Introduction and Aims: The Traveller community as ethnic minority is vulnerable to problematic alcohol use, because of social exclusion, discrimination, lack of awareness and difficulties in engaging with addiction treatment protocols.

Design and Methods: This research yielded an exploratory account of Travellers and alcohol use according to the perspectives of the Travellers and key service providers in the west of Ireland, within the context of a large-scale study on Travellers and substance use. The research consisted of 12 peer-accompanied focus groups of Traveller men and women (n = 57) and 45 semi-structured interviews with a self-selecting sample of key service agencies. The research themes related to Traveller culture and alcohol use, sex differences, reasons for consuming alcohol, attitude to alcohol use, problematic alcohol use, levels of alcohol harm-related knowledge, perceptions of alcohol-related risk and experiences of addiction services. A thematic analysis of the information garnered guided this comparative analysis.

Results: The Traveller community, and in particular Traveller men, are presenting with increasingly problematic alcohol use, because of dissipation of their culture and their experiences of marginalisation, discrimination, depression, illiteracy and poverty. Difficulties engaging with law enforcement, community health and addiction services compromise their efforts to deal with this problem and home detoxification attempts are common.

Discussion and Conclusions: Services must aim to take into consideration the cultural needs of Travellers and provide appropriate educational materials, peer education programs and flexible treatment approaches for those Travellers experiencing problematic alcohol use.

(Compiled by Louise Farragher)

Upcoming events

(Compiled by Louise Farragher – lfarragher@hrb.ie)

February

4 February 2010

Right here, right now – The third DDN/Alliance national service user involvement conference
Venue: Holiday Inn, Birmingham city centre
Organised by/Contact: Ian Ralph (Tel: +44 (0)20 7463 2081 or Faye Liddle (Tel: +44 (0)20 7463 2205) for further information or book online
www.cjwellings.com/righthererightnow

Information: Building on the success of 'Nothing about us without us' in 2007 and last year's 'Voices for choices', this event will feature inspirational presentations from service users from all different backgrounds and throw open new challenges for better policy and practice.

This conference will enable those who use drug and alcohol services, alongside treatment providers, policymakers, DAAT co-ordinators, commissioners and drug and alcohol workers, to feed in their experiences of what's working and what's not – and to share ideas for brighter and better service user involvement. The event will once again showcase the country's innovative service user groups, who are invited to be part of a vibrant exhibition, and the video booth will be open for vox pops and feedback for the special issue of *Drink and Drugs News*.

March

15–16 March 2010

Fourth Annual Conference of the International Society for the Study of Drug Policy
Venue: Santa Monica, USA
Organised by/Contact: RAND Drug Policy Research Center and UCLA's Integrated Substance Abuse Program
www.rand.org/multi/dprc/issdp2010/index.html

Information: The theme of the conference is 'The future of drug policy: trends in policy, research to practice and practices that should be researched.' The conference should be of interest to policy makers, practitioners and academics from a wide array of disciplines who are engaged in drug policy analyses pertaining to drug markets, the harms caused by both the supply of and demand for drugs, and the intended and unintended consequences of policy.

Anticipated plenary speakers include:

- *Antonio Maria Costa, Executive Director, United Nations Office on Drugs and Crime*
- *Tom McLellan, Deputy Director, US Office of National Drug Control Policy (confirmed)*
- *María Elena Medina-Mora, General Director, National Institute of Psychiatry in Mexico, and former member of the International Narcotics Control Board (confirmed)*
- *Dr Zunyou Wu, Director, National Center for AIDS/STD Control and Prevention, Chinese Center for Disease Control and Prevention (confirmed).*

Immediately after the conference, on 17th March, there will be an ISSDP workshop on sociological and anthropological contributions to drug policy studies, under the title 'Drugs, culture and society'. On the afternoon of 17th March there will also be a workshop on Developments in longitudinal modeling of drug use and associated outcomes.

15–18 March 2010

KBS Thematic conference: Alcohol and violence – relationships, causality, and policy
Venue: Turning Point Alcohol and Drug Centre, Melbourne
Organised by/Contact: Kettil Bruun Society for Social and Epidemiological Research on Alcohol
www.kettilbruun.org/Violence_Melb.htm

Information: The role of alcohol in violence has been in the news in Australia and some other countries recently. Meanwhile, a number of different research traditions have expanded our knowledge about when and how there are links, the magnitude of the relationships, and the effectiveness of policy and program interventions to reduce alcohol-related violence.

In this context, a thematic meeting of the Kettil Bruun Society for Social and Epidemiological Research on Alcohol will be hosted by the AER Alcohol Policy Research Centre at Turning Point Alcohol and Drug Centre. The organising committee includes Peter d'Abbs, Kate Graham, Michael Livingston and Robin Room.

April

22–23 April 2010

15th National Conference – Working with Drug and Alcohol Users in Primary Care
Venue: SECC, Glasgow
Organised by/Contact: Royal College of General Practitioners, Sex, Drugs and HIV Task Group
www.healthcare-events.co.uk/conf/booking
php?action=home&id=404

Information: This conference is the largest event in the UK for GPs, shared care workers, drug users, nurses and other primary care staff, specialists, commissioners and researchers interested in and involved with the management of drug and alcohol users in primary care.

The topics to be covered include:

- Exploring the recovery debate and personalisation of treatment
- Redefining harm reduction
- Linkages between substance use, deprivation, and social exclusion
- Hidden harm in primary care
- Tackling hepatitis C – have we got it right?

Upcoming events *(continued)*

Speakers include:

- *Ethan Nadelmann, US Drug Policy Alliance*
- *David Liddell, Director of Scottish Drugs Forum*
- *Dr Mary Hepburn, Princess Royal Maternity Hospital*
- *Dr David McCartney, Lothian and Edinburgh Abstinence Programme (LEAP)*
- *Dr Roy Robertson, Edinburgh GP and Reader at Edinburgh University*

25–29 April 2010

Harm Reduction 2010: IHRA 21st International Conference
Venue: BT Convention Centre, Liverpool.
Organised by/Contact: International Harm Reduction Association
www.ihra.net/Liverpool/Home

Information: Harm Reduction: The Next Generation is the theme of this conference. There are now two and a half decades of harm reduction experience. A substantial body of evidence shows the feasibility and effectiveness of harm reduction in a wide variety of social and cultural settings.

But what is needed as we move through to the third decade of harm reduction? How adequate are the models of harm reduction that have been developed? Is the 'comprehensive package' of harm reduction for HIV sustainable in low and middle income countries?

This theme will be reflected throughout the conference programme, and has been chosen to embody:

- Young People – who are both directly and indirectly affected by drug use around the world, and must be engaged in the global harm reduction and drug policy dialogue
- New Populations – including regions such as Africa and Latin America, which have often been overlooked by harm reduction advocates and policies
- New Interventions – including the need to address non-injecting use, and to move beyond a focus on opiates and develop effective responses for stimulant users and emerging drugs and trends
- New Challenges – including the need to improve global resourcing for harm reduction, and to improve quality as well as coverage around the world.

June

23–25 June 2010

Drugs alcohol and criminal justice: ethics, effectiveness and economics of interventions
Venue: Friends House, 173–177 Euston Road, London NW1 2BJ
Organised by/Contact: Conference Consortium, conference@conferenceconsortium.org
www.connectionsproject.eu/conference2010

Information: The 'Connections' Project, launched in Autumn 2007, managed by The European Institute of Social Services (EISS) of the University of Kent and co-funded by the European Commission Public Health Programme focuses on the potential for partnerships within criminal justice systems of the EU Member States to develop joined-up responses to drugs and related-infections, particularly HIV/AIDS and hepatitis.

The University of Kent is delighted to announce the Second European Conference of the Connections Project, organised by the Conference Consortium and supported by Drink and Drugs News and Napo.

The conference takes place at a time of unprecedented competition for scarce resources everywhere. To be able to demonstrate 'value for money' is critical and nowhere is this more so than in drug and alcohol treatment. Following previous conferences where we have examined the various treatment models and interventions available, this event will seek to tease out how different modalities can be delivered and combined to construct a comprehensive treatment system, offering accessible and effective options to those requiring help, demonstrating value for money.

The conference will look at a range of interventions and treatments, from harm reduction to drug free 'recovery'. The premise is that no one treatment modality can deal effectively with the complex range of presented need. The task of the conference is to discuss and debate how best the different components can be combined most effectively. Within the context of criminal justice systems, some of the key issues for the conference will be:

- Access and equivalence – what right do service users have, are they 'a patient or a prisoner'?
- Evidence and effectiveness – what really works and how do we demonstrate this?
- How can we reconcile different philosophies and shape a system based on choice and plurality?
- Who decides what is offered and when – how do we ensure the 'informed consent' and is there a place for compulsion?
- What role should and can service users play in service design and delivery?

August

24–27 August 2010

11th EASA Biennial Conference: Crisis and imagination
Venue: National University of Ireland, Maynooth

Organised by/Contact: European Association of Social Anthropologists
www.easaonline.org/conferences/easa2010/index.htm

Workshop 058: Alcohol, culture and motherhood
Exact date and venue: TBC

Workshop convenors: Tanya Cassidy (NUIM) tcassidy@uwindsor.ca
Anne Fox (Galahad SMS Ltd/UCL)

Information: Alcohol and cultural associations have been studied for a number of years and linked to important topics such as identity and gender. Traditional anthropological studies have found a near cross-cultural universal that, in

Upcoming events *(continued)*

nations where alcohol is consumed, males tend to imbibe at a higher rate, whereas women are more likely to abstain. Two key exceptions to this cross-cultural gender division occur in Greece and in modern Ireland. Ireland, perhaps more than any other nation, is linked to the imaginings of alcohol, and recent studies have shown that younger Irish females may consume more than their male counterparts, which has sparked notions of a new 'crisis', which is of course not new or unique to Irish commentators.

Significantly, these younger women are of childbearing age, and the image of the female drunkard is inextricably associated with inept motherhood in the public imagination (an image dating back to Hogarth's Gin Lane [175]).

In a Europe which is redefining notions of motherhood, it behoves us to take stock of such imaginings in Europe around the so-called historical and cultural 'crisis' of mothers who drink.

This workshop will investigate these complicated imaginings of 'crisis' and its implications not only for children, but also for their mothers, and for nation states as they react to globalised health concerns regarding alcohol. Critical ethnographic discussions of issues associated with the increasingly accepted demonisation of a maternal drinker are clearly linked to images of mothers in general, and perhaps to alcohol as a cultural object more specifically.

HRB strategy and organisational change

In December the Health Research Board launched its strategic business plan for 2010 –2014. The strategy sets out a new approach to funding research and a realignment of the HRB's resources to concentrate on providing direct benefits for patients, for population health and for the health system.

Until recently, the HRB comprised a number of units with responsibility for research funding and a number of units, such as the Alcohol and Drug Research Unit, with responsibility for maintaining national health information systems and using evidence derived from these systems and other discrete research projects to support decision making in services management and policy formation. Under the new strategy, the work of the HRB will be carried out in a new arrangement of units that will help to provide a more integrated approach to the task of translating research findings into health benefits.

Work on the national health information systems, such as the NDTRS and the NDRDI, will continue as before. The HRB will remain as Ireland's focal point for the European Monitoring Centre for Drugs and Drug Addiction, and the National Documentation Centre will continue its research dissemination and educational work. Contact details for all staff working on the information systems, in the NDC and on drug and alcohol research within the HRB will remain the same as before. Therefore, while there will no longer be a distinct drug an alcohol research unit in the HRB, we do not envisage that the transition to our new organisational structure will affect our working relationships or communication with our stakeholders in any way.

We want to take this opportunity to thank you for your support and your interest in our work over the years and to wish you a Happy New Year. We look forward to working with you in 2010.

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